

CMS-10434 OMB 0938-1188

**Package Information**

**Package ID** RI2018MS00070  
**Program Name** CEDAR Health Homes  
**SPA ID** RI-18-0009  
**Version Number** 2  
**Submitted By** Melody Lawrence  
**Package Disposition**



**Submission Type** Official  
**State** RI  
**Region** Boston, MA  
**Package Status** Approved  
**Submission Date** 8/7/2018  
**Approval Date** 10/17/2018 3:02 PM EDT

## Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-14-26  
Baltimore, Maryland 21244-1850



**Date:** 10/17/2018

**Head of Agency:** Elizabeth Roberts

**Title/Dept :** Secretary of Health and Human Services

**Address 1:** 74 West Road

**Address 2:**

**City:** Cranston

**State:** RI

**Zip:** 02920

**MACPro Package ID:** RI2018MS00070

**SPA ID:** RI-18-0009

**Subject**

Approval Notification

**Dear Elizabeth Roberts**

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for Approval

Reviewable Unit	Effective Date
Health Homes Intro	7/1/2018
Health Homes Geographic Limitations	7/1/2018
Health Homes Population and Enrollment Criteria	7/1/2018
Health Homes Providers	7/1/2018
Health Homes Service Delivery Systems	7/1/2018
Health Homes Payment Methodologies	7/1/2018
Health Homes Services	7/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2018

For payments made to Health Homes providers under this new Health Homes Program submission package a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 7/1/2018 to 6/30/2020.

Corrections: Replace Elizabeth Roberts with Secretary Beane (State needs to update their system profile) and 90% FMAP is not available as this is not a new Health Homes SPA and has already used the full 8 quarters of enhanced match.

A full approval letter will be sent in hard copy under separate cover.

Sincerely,

Mike Nardone

Mr.

## Approval Documentation

Name

Date Created

RI 18-009 app let.final

10/25/2018 12:05 PM EDT



## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

### Package Header

**Package ID** RI2018MS00070  
**Submission Type** Official  
**Approval Date** 10/17/2018  
**Superseded SPA ID** N/A


**SPA ID** RI-18-0009  
**Initial Submission Date** 8/7/2018  
**Effective Date** N/A


### State Information

**State/Territory Name:** Rhode Island

**Medicaid Agency Name:** Executive Office of Health and Human Services

### Submission Component

 State Plan Amendment

 Medicaid

 CHIP

**Submission - Summary**

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

**Package Header****Package ID** RI2018MS00070**SPA ID** RI-18-0009**Submission Type** Official**Initial Submission Date** 8/7/2018**Approval Date** 10/17/2018**Effective Date** N/A**Superseded SPA ID** N/A**SPA ID and Effective Date****SPA ID** RI-18-0009**Reviewable Unit****Proposed Effective Date****Superseded SPA ID**

No items available

## Submission - Summary

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## Package Header

Package ID	RI2018MS00070	SPA ID	RI-18-0009
Submission Type	Official	Initial Submission Date	8/7/2018
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Superseded SPA ID	N/A		

## Executive Summary

**Summary Description Including Goals and Objectives** Cedar Health Homes are designed for Medicaid recipients under the age of 21 who meet the following criteria are eligible for Cedar Services: 1) Suspected of having a severe mental illness, or severe emotional disturbance, 2) Suspected of having two or more of the following chronic conditions Mental Health Condition, Asthma, Diabetes, Developmental Disabilities, Down Syndrome, Mental Retardation, or Seizure Disorders; or 3) has one chronic condition listed previously and is at risk of developing a second.

Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and referral to, evidence based medically necessary service that may be available for children pursuant to federal EPSDT requirements, and referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes operate as "Designated Providers" of Health Home Services. The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

Cedar Family Centers aim to connect children and their families with appropriate, evidence based medically necessary services, and to empower and build a family's skills to successfully navigate systems of care and advocate for their child(ren) and family.

Beginning July 1, 2018, Cedar Family Services will be carved into the Managed Care contracts and will no longer be paid through FFS only. Cedar Family Services will now be available through both Fee-For Service and Managed Care Delivery Systems.

## Federal Budget Impact and Statute/Regulation Citation

### Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	\$0
Second	2019	\$0

### Federal Statute / Regulation Citation

Section 2703 of the Patient Protection and Affordable Care Act of 2010

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created
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No items available

## Submission - Summary

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**Effective Date** N/A

### Governor's Office Review

- ☐ No comment  
☐ Comments received  
☐ No response within 45 days  
☒ Other

**Describe** This amendment has not been reviewed specifically with the Governor's Office. Under the Rhode Island Medicaid State Plan, the Governor has elected not to review the details of state plan materials. However, in accordance with Rhode Island law and practice, the Governor is kept apprised of major changes in the state plan.

## Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

CMS-10434 OMB 0938-1188

### The submission includes the following:

☐ Administration

☐ Eligibility

☐ Benefits and Payments

☐ Health Homes Program

☒ Create new Health Homes program

☐ Amend existing Health Homes program

☐ Terminate existing Health Homes program

\* ☒ Copy from existing Health Homes program

☐ Create new program from blank form

\* Name of Health Homes Program: CEDAR Health Homes

## Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

### Package Header

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<b>Approval Date</b> 10/17/2018	<b>Effective Date</b> N/A
<b>Superseded SPA ID</b> N/A	

#### Name of Health Homes Program

CEDAR Health Homes

#### Indicate whether public comment was solicited with respect to this submission.

- ☐ Public notice was not federally required and comment was not solicited
- ☐ Public notice was not federally required, but comment was solicited
- ☒ Public notice was federally required and comment was solicited

#### Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism

**Date of Email or other electronic notification:** Jun 29, 2018

**Description of mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used:** Stakeholders, providers, and sister state agencies

☐ Website Notice

#### Select the type of website

☐ Website of the State Medicaid Agency or Responsible Agency

**Date of Posting:** Jun 29, 2018

**Website URL:** <http://www.eohhs.ri.gov/ReferenceCenter/MedicaidStatePlanand1115Waiver/5PAand1115WaiverChanges.aspx>

☐ Website for State Regulations

☐ Other

☐ Public Hearing or Meeting

☐ Other method

#### Upload copies of public notices and other documents used

Name	Date Created
18-009 Interested Parties - Cedar In-Plan_6.29.18	8/7/2018 2:58 PM EDT
18-009 Notice to Public - Cedar In-Plan_6.29.18	8/7/2018 2:58 PM EDT

PDF

PDF

#### Upload with this application a written summary of public comments received (optional)

Name	Date Created
No items available	

No items available

#### Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology



- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

## Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

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Superseded SPA ID	N/A		

#### Name of Health Homes Program

CEDAR Health Homes

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

☒ Yes  
☐ No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

☒ Yes  
☐ No

☐ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

☐ All Indian Health Programs

Date of solicitation/consultation:

6/29/2018

Method of solicitation/consultation:

Email and USPS

☐ All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☐ All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name

Date Created

18-009 Tribal Notification 18-010\_6.29.18

8/7/2018 2:23 PM EDT



Indicate the key issues raised (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

☐ Eligibility

☐ Benefits

☐ Service delivery

☐ Other issue

## Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

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**Superseded SPA ID** N/A

### SAMHSA Consultation

#### Name of Health Homes Program

CEDAR Health Homes

#### Date of consultation

4/21/2011

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

# Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

## Package Header

<b>Package ID</b> RI2018MS00070	<b>SPA ID</b> RI-18-0009
<b>Submission Type</b> Official	<b>Initial Submission Date</b> 8/7/2018
<b>Approval Date</b> 10/17/2018	<b>Effective Date</b> 7/1/2018
<b>Superseded SPA ID</b> N/A	

## Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

### Name of Health Homes Program

CEDAR Health Homes

## Executive Summary

**Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used**

Data conversion from previous Medicaid Model Data Lab.

Supersedes Transmittal Number:11-006

Transmittal Number:16-0001

This State Plan Amendment is in Attachment 3.1-H(14) of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B(TN 09-004) of the State Plan.

Medicaid recipients under the age of 21 who meet the following criteria are eligible for Cedar Services: 1) Suspected of having a severe mental illness, or severe emotional disturbance, 2) Suspected of having two or more of the following chronic conditions Mental Health Condition, Asthma, Diabetes, Developmental Disabilities, Down Syndrome, Mental Retardation, or Seizure Disorders; or 3) has one chronic condition listed previously and is at risk of developing a second. Cedar Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. Eligible clients are free to choose from any Cedar Family Center to receive services. Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and referral to, evidence based medically necessary service that may be available for children pursuant to federal EPSDT requirements, and referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. The CHH Team minimally consists of a Licensed Clinician and a Family Service Coordinator. The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Medical Specialists and other Medical professionals will be included on the CHH Team based on the unique needs of each enrolled child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

Cedar Family Centers aim to connect children and their families with appropriate, evidence based medically necessary services, and to empower and build a family's skills to successfully navigate systems of care and advocate for their child(ren) and family.

Beginning July 1, 2018, Cedar Family Services will be carved into the Managed Care contracts and will no longer be paid through FFS only. Cedar Family Services will now be available through both Fee-For Service and Managed Care Delivery Systems.

## General Assurances

- ☐ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☐ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☐ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☐ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☐ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☐ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

## Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

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Effective Date 7/1/2018

Superseded SPA ID N/A

- ☒ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☐ Health Homes services will be provided in a geographic phased-in approach

# Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

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<b>Superseded SPA ID</b>	N/A		

## Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

☐ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

### Mandatory Medically Needy

☐ Medically Needy Pregnant Women

☐ Medically Needy Children under Age 18

### Optional Medically Needy (select the groups included in the population)

#### **Families and Adults**

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

#### **Aged, Blind and Disabled**

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

## Health Homes Population and Enrollment Criteria

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<b>Superseded SPA ID</b> N/A	

### Population Criteria

The state elects to offer Health Homes services to individuals with

☐ Two or more chronic conditions

#### Specify the conditions included

- ☐ Mental Health Condition
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI over 25
- ☐ Other (specify)

Name	Description
Developmental Disability	Developmental Disability
Down Syndrome	Down Syndrome
Mental Retardation	Mental Retardation
Seizure Disorders	Seizure Disorders

☐ One chronic condition and the risk of developing another

#### Specify the conditions included

- ☐ Mental Health Condition
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI over 25
- ☐ Other (specify)

Name	Description
Developmental Disability	Developmental Disability
Down Syndrome	Down Syndrome
Mental Retardation	Mental Retardation
Seizure Disorders	Seizure Disorders

#### Specify the criteria for at risk of developing another chronic condition

Cedars will review medical records and collaborate with other service providers to assess if there is any evidence of risk factors present (such as meeting developmental milestones, activity level, weight, family history etc.). For individuals enrolled in managed care, designated care managers may also collaborate with Cedars, or refer children for assessment. Cedars look at the child's clinical and treatment history to get an idea of their overall progress and functioning as well as the child and family's ability to engage in treatment. Overall family functioning plays a major role in determining family and environmental risk factors that could play into future clinical needs. For instance, a family history of substance abuse or mental health needs may put the child at risk for other medical and behavioral health needs (i.e. a parent who struggles with their own mental health needs may have difficulty following through with OT recommendations which may lead to increased medical problems and the need for more involved therapy).

Medicaid recipients who meet the following criteria are eligible for Cedar

Services:

- o Suspected of having a severe mental illness, or severe emotional disturbance
- o Suspected of having two or more chronic conditions as listed below:
  - o Mental Health Condition
  - o Asthma
  - o Diabetes
  - o Developmental Disabilities
  - o Down Syndrome
  - o Mental Retardation
  - o Seizure Disorders
- o Has one chronic condition listed above and is at risk of developing a second

☐ One serious and persistent mental health condition

**Specify the criteria for a serious and persistent mental health condition**

As defined by SAMHSA, "Serious Emotional Disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities."



## Health Homes Population and Enrollment Criteria

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Superseded SPA ID N/A

### Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- ☒ Opt-In to Health Homes provider
- ☐ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

#### Describe the process used

Families may access a Cedar Family Center through self-referral or by other referral sources, including a Primary Care Physician, a Health Plan or other providers. The enrollment process does not differ across delivery systems. For individuals enrolled in managed care, designated care managers may also collaborate with Cedars, or refer children for assessment. When these sources initiate the referral, the Cedar Family Center must contact the family within ten (10) calendar days of referral. Cedar shall document attempts made to reach the family and response to the referral source.

A family may choose to use a Cedar Family Center for assessment of needs, referral, and care coordination. The Cedar staff will assist the family in identifying and coordinating services and supports. The Cedar staff will work with the family to support efforts to gain access to needed services and to track receipt of services.

Cedar Services are voluntary and the family may opt out at any time. Families may choose any certified Cedar Family Center. Families consent to treatment, in writing, with the Cedar Family Center of their choosing.

# Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

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## Types of Health Homes Providers

☐ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- ☐ Physicians
- ☐ Clinical Practices or Clinical Group Practices
- ☐ Rural Health Clinics
- ☐ Community Health Centers
- ☐ Community Mental Health Centers
- ☐ Home Health Agencies
- ☐ Case Management Agencies

### Describe the Provider Qualifications and Standards

Cedar Family Centers require RI state certification by the Executive Office of Health and Human Services (EOHHS) and must follow the EOHHS Practice Standards established for Cedar Family Centers. Link to updated standards: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ProviderManuals/CedarCertStds.pdf>

- ☐ Community/Behavioral Health Agencies
- ☐ Federally Qualified Health Centers (FQHC)
- ☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

## Provider Infrastructure

### Describe the infrastructure of provider arrangements for Health Home Services

Designated Providers as described in Section 1945(h)(5)

Cedar Family Centers meeting the Health Homes criteria as established by the State in consultation with CMS will be certified by the State as Health Home providers. Cedar family centers currently operate under Certification Standards established by the State. Certification Standards have been amended as required to ensure they meet Health Home requirements. Eligible clients are free to choose from any Cedar Family Center to receive services. Cedar Family Centers are designed to provide a structured system for facilitating the assessment of need for, and the provision of high quality, evidence based medically necessary service that may be available for children pursuant to federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) requirements, as well as referrals to community based services and supports that benefit the child and family. Cedar Family Center Health Homes will operate as a "Designated Provider" of Health Home Services. All Cedar Family Centers employ independently licensed health care professional such as; Psychologists licensed Independent Clinical Social Workers Masters Level Registered Nurses, or licensed Marriage and Family Therapists; Cedar Family centers also employ staff trained to provide care coordination, individual and family support and other functions expected from a health home. The CHH Team minimally consists of a Licensed Clinician and a Family Service Coordinator, The CHH Team will consult, coordinate and collaborate on a regular basis with the child's Primary Care Physician/Medical Home and with other providers providing treatment services to that child. Medical Specialists and other Medical professionals will be included on the CHH Team based on the unique needs of each enrolled child. Cedar Family Centers, by Standard, provide all services in a patient and family centered manner.

## Supports for Health Homes Providers

### Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

#### Description

Technical assistance is offered to providers through monthly site visit meetings. Topics of discussion include: development of new informational materials-outreach efforts, code and diagnosis for billing, Kidsnet, billing segments, crisis plan development, Professional Development system (care coordination planning committee), RI Community Health Team collaboration, PCP and Health Plan coordination, Kidsnet- user roles and data sharing, hearings and complaints, FCCP/DCYF involved families, collaboration with direct service providers, performance measures/outcomes measures, and the Common Referral Tool. The frequency of learning collaboratives vary, but are typically held at least twice annually. The learning collaboratives provide Cedars with an opportunity to learn best practices in various areas such as care coordination, integration of HIT, population health management, behavioral health, patient engagement, etc. Learning collaboratives are not mandatory, but providers are strongly encouraged to attend. Cedars are typically very proficient in utilizing HIT. Therefore, specific trainings on the adoption and use of HIT, such as integration with KIDSNET, will be provided on an ad hoc basis if there is a need. EOHHS assesses the Cedar Health Homes upon certification to determine readiness and identify any needs for additional training. The information that Cedar Health Homes are required to provide as part of their application for certification includes, but is not limited to; organizational background information, organizational structure, description of program approach (including family centeredness, community focus, staff competency, organizational capacities, ability to demonstrate relationships with provider community, scope of practice), quality improvement plan, compliance processes and procedures, administrative and financial systems, independent audits, ownership and control interests, and mechanisms for data collection and reporting of outcome measures.

#### Other Health Homes Provider Standards

##### The state's requirements and expectations for Health Homes providers are as follows

Rhode Island has established Certification Standards for Cedar Family Centers and will utilize those Standards as the basis to certify Health Home providers. The Standards can be found at: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ProviderManuals/CedarCertStds.pdf>

In addition an appendix to the existing Certification Standards (Appendix VI) has been developed which relates to the Health Homes initiative the text of the Appendix follows:

##### Introduction

Section 2703 of the Patient Protection and Affordable Care of 2010 afforded States the option of adding "Health Homes for Enrollees with Chronic Conditions" to the scope of services offered to individuals receiving Medicaid by applying for an Amendment to the RI Medicaid State Plan. This provision is an important opportunity for Rhode Island to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness.

The Rhode Island Executive Office of Health and Human Services (EOHHS), as the designated Medicaid entity, submitted a request to the Centers for Medicare and Medicaid Services (CMS) on August 26, 2011, to designate Cedar Family Centers as Health Homes for Children and Youth with Disabilities and Chronic conditions.

The design of the Cedar System of Care and the Cedar Family Centers makes this a unique opportunity to implement the principles of Section 2703 Health Homes within an existing infrastructure of providers, trained professionals and engaged stakeholders. Utilizing Cedar Family Centers as Health Home providers allows RI to begin implementing this program with a minimum of delay and expenditure of valuable resources.

CMS has issued guidelines (summarized below) to the State on required services, eligibility criteria, quality management and program evaluation. For purposes of the Health Homes initiative all current and future Certified Cedar Family Centers will be required to abide by these requirements, in addition to the existing Cedar Certification Standards as revised in 2009.

##### Provider Standards

As previously mentioned, the current Cedar certification standards, under which all Cedar Family Centers operate will be utilized as the Provider Standards for Cedar Health Homes. In addition all providers of Health Home Services agree to:

- o Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- o Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- o Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- o Coordinate and provide access to mental health and substance abuse services;
- o Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- o Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- o Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- o Coordinate and provide access to long-term care supports and services;
- o Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
- o Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- o Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- \* Establish a protocol to gather, store and transmit to the State all data elements required to fulfill the reporting requirements of the Health Home Initiative.

Cedar family Centers are strongly encouraged to attend learning collaboratives, as offered, to increase their collaboration and integration with the State of RI's patient centered medical home initiative for children. Families may access a Cedar Family Center through self-referral or by other referral sources, including a Primary Care Physician, a Health Plan or other providers. When these sources initiate the referral, the Cedar Family Center must contact the family within ten (10) calendar days of referral. Cedar shall document attempts made to reach the family and response to the referral source.

The Cedars currently receive some admission/discharge notifications via fax, call or email from the medical/psychiatric inpatient facilities. To improve upon this

process, the Cedars do active outreach to the medical/psychiatric inpatient facilities to remind the facilities of their request to receive admission/discharge notifications in order to facilitate effective transitional care.

Name

Date Created

No items available

## Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

### Package Header

Package ID RI2018MS00070

SPA ID RI-18-0009

Submission Type Official

Initial Submission Date 8/7/2018

Approval Date 10/17/2018

Effective Date 7/1/2018

Superseded SPA ID N/A

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☐ Fee for Service
- ☐ PCCM
- ☐ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ☒ Yes
- ☐ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

Health Home Services:

The MCOs will be required to provide family-centered, intensive care management and coordination services to children. These services include the following:

- Comprehensive care management;
- Care coordination;
- Referral to community and social support services (formal and informal);
- Individual and family support services;
- Comprehensive transitional care; and
- Health promotion

Services will focus on providing enhanced guidance and psychoeducation to promote health and wellness by helping families understand their child's clinical needs, health conditions, medical needs, and/or risk and protective factors. Care coordination is required to include in-home, hands-on support and coaching to build a family's skills to successfully navigate systems of care and advocate for their child(ren) and family. Services must be delivered by providers who have experience in delivering health homes in a family's place of residence/community and are trusted members of the communities where members reside.

Network Adequacy:

MCOs are required to maintain and monitor a network of appropriate providers and to demonstrate their ability to provide the required covered services as outlined in the contract with EOHHS.

MCOs must consider the following when establishing and maintaining provider networks:

- Anticipated enrollment
- Ability to provide all enrolled Medicaid children a full continuum of behavioral health and substance use disorder services. This must include all levels of need.
- Expected utilization of services
- Numbers and types (in terms of training, experience, and specialization) of providers
- Numbers of providers who are not accepting new Medicaid patients
- Geographic location of providers and members, considering distance, travel time, and the availability of transportation
- Cultural Competency of providers and office staff.
- Disability Competency of providers and the physical accessibility of their offices.

Reporting Requirements:

The Health Plans are required to comply with all reporting requirements established by EOHHS. EOHHS develops and maintains a Managed Care

Reporting Calendar that is shared with the MCOs and outlines all required reporting. Any Cedar reports will be included in the Managed Care Reporting Calendar.

#### Quality:

MCOs are contractually required to submit quality data as it pertains to EOHHS' quality strategy. Additionally, the Health Plans make available internal quality assurance reports, provide the results of quality improvement studies and/or projects, and share Medicaid and CAHPS results with the state. The MCOs collect member satisfaction data at least annually.

- ☐ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name

Date Created

No items available

#### The State intends to include the Health Home payments in the Health Plan capitation rate

☒ Yes

☐ No

**Assurances** ☐ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☐ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☐ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

## Package Header

Package ID RI2018MS00070

SPA ID RI-18-0009

Submission Type Official

Initial Submission Date 8/7/2018

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## Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

☐ Tiered Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

**Describe below**

There are no tiered rates within the payment methodology.

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided**

FFS Payment Methodology: There are variations in payment based on individual care needs. Cedar Family Centers will receive an initial payment of \$900.00 upon completion and submitted claims for the following deliverables: (1) An assessment of the family; and (2) Family Care Plan. Cedar Family Centers will then receive a Per Member Per Month (PMPM) of \$25.00 upon submission of at least one claim per month totaling a minimum of one hour of child and/or family contact directly related to the achievement of action plan goals. Therefore, depending on the amount and/or frequency of care needed, the provider may receive additional monthly payments based on the individual's care needs.

Managed Care Payment Methodology: The state will include dollars for the Health Home payments in the Health Plan capitation rate. MCOs and qualified providers will develop a payment rate and methodology. EOHHS will monitor access to Health Home services in order to ensure that MCO rates are adequate to establish and maintain a robust provider network.

**Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.**

Cedar Family Centers will receive an initial payment of \$900.00 upon completion and submitted claims for the following deliverables: (1) An assessment of the family; and (2) Family Care Plan. Cedar Family Centers will then receive a Per Member Per Month (PMPM) of \$25.00 upon submission of

at least one claim per month totaling a minimum of one hour of child and/or family contact directly related to the achievement of action plan goals.

Twice annually, the EOHHS will conduct claims data reviews as well as Cedar Record Reviews during on site record reviews to ensure that the billed services were delivered and that all deliverables are complete and of a high quality. EOHHS will review a random sample of 5% of the open cases and 5% of the closed cases (minimum of ten (10) or maximum of forty (40) records). During the record reviews, EOHHS will review the following: timeliness of assessment, diagnosis, clinical endorsement, client/parent/caregiver endorsement, complete components of an assessment, complete components of a family care plan, crisis planning, care coordination aligned with family care plan, health promotion aligned with family care plan, face to face interactions with client/family, formal and informal connections aligned with family care plan, health screening (BMI, Depression screen) and Family Satisfaction Surveys.

The EOHHS and Cedar Family Centers will establish a performance baseline for which each Cedar will be held accountable to achieve based on data collected from the above mentioned Cedar Record Reviews. On a yearly basis, if a Cedar does not reach the established baseline, they may be subject to a 10% recoupment of funds.

## Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

### Package Header

<b>Package ID</b>	RI2018MS00070	<b>SPA ID</b>	RI-18-0009
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	8/7/2018
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<b>Superseded SPA ID</b>	N/A		

### Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

**Describe below how non-duplication of payment will be achieved** EOHHS will ensure non-duplication of payment for similar services through regular monitoring of the State of RI MMIS system which employs system edits that ensure non-duplication.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

### Optional Supporting Material Upload

Name

Date Created

No items available



# Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

## Package Header

<b>Package ID</b> RI2018MS00070	<b>SPA ID</b> RI-18-0009
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<b>Superseded SPA ID</b> N/A	

## Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

### Comprehensive Care Management

#### Definition

Comprehensive CM services are conducted with an individual and involves the identification, development, and implementation of a care plan that addresses the needs of the whole person. CM includes providing access to and the coordination of long term services and supports. Comprehensive CM is provided by Cedar Family Centers by working with the child/family to assess current issues, identify continuing needs, and identify resources/services to assist the child/family to address needs through an Assessment and development of a Family Care Plan (FCP). For individuals enrolled in Medicaid Managed Care who have a designated Care Manager, the MCO care manager may work in consultation with Cedar. They may initiate referrals to Cedar services, and may coordinate, in consultation with Cedar, necessary services included in the FCP. Interventions/objectives identified in the FCP should map back to child and family's designated outcomes and must include; action steps, timelines for completion, responsible parties, and date action step is achieved. FCP shall be developed with the family in coordination with existing community resources and is based on assessment information, strengths/needs of the child/family and on clinical protocols which indicate the types and intensity of care considered medically necessary. Support shall be targeted to occur in the most natural environment and in the least restrictive setting. FCP can include a referral to direct treatment or support services and Cedar direct supports/care coordination and should identify both natural/formal supports needed. Natural supports are individuals identified by the youth and family who know the youth and family well and who provide support without being paid. Where formal supports are involved, attention should be given toward building on the strengths of the child, family, extended family and community supports to support long-term empowerment. An Assessment must be completed within 45 calendar days of initial request and the FCP must be completed within 45 calendar days from referral. A Needs Assessment and Family Care Plan may be in place for up to twelve (12) months. Updates shall be added, if needed, to the assessment and plan throughout the course of the case opening. The FCP must be developed with and signed by the child's parents/guardians as an agreement to work towards the action plan. FCPs must be reviewed and signed by clinician on an annual basis. If the child or family's needs change additional information can be obtained as needed.

#### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Cedar Family Centers utilize a secure HIPAA compliant electronic case management system to support the activities required in order to provide Comprehensive Care Management. These activities include: identifying client needs by gathering data from other resources including: medical and human service providers, school programs. Integrating the information into the treatment planning process. Developing the child specific Action Plan. Facilitate cross-system coordination, integration and supports access to service interventions to address the medical, social, behavioral and other needs of the child. Assure active participation of the eligible child and family in the provision of care, assessment of progress and collection and analysis of both utilization and outcome data. Submit quarterly submission of enrollment data, with family notice and opportunity to opt out, to the RI Department of Health for the KIDSNET system. CEDARAccess RI KIDSNET Child Health Information System which provides access to information vital to the provision of Comprehensive Care Management. This information includes: Blood Lead levels, Immunizations, Newborn Developmental Assessment, Hearing Assessment, WIC and Early Intervention participation CEDAR

#### Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

#### Description

BH Professional or Specialist - Description: Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures - LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Must have experience working with Children with Special Health Care Needs. Information for the Assessment and Family Care Plan may be collected by a licensed clinician. Each Assessment and Family Care plan must be reviewed and signed by an independently licensed clinician and may be in place for up to twelve (12) months.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians☐ Nutritionists☐ Other (specify)**Provider Type****Description**

Family Service Coordinator

Information for the Assessment and Family Care Plan may be collected by a Family Service Coordinator. Family Service Coordinators must have direct experience in, knowledge of, or demonstrate capacity in strength-based family centered practice, needs assessment and care plan development, community resources available to children and families, medical complexities, Autism Spectrum Disorders, behavioral health, developmental disabilities, and legal issues experienced by families of children with special health care needs.

**Care Coordination****Definition**

Care coordination is the implementation of the Action Plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate, vocational educational services. Services must be coordinated and information must be centralized and readily available to all team members. Care coordination also includes providing access to and the coordination of long term services and supports. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant information is to be obtained and reviewed by the team. Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified by developing linkages and skills. In order for families to reach their full potential and increase their independence in obtaining and accessing services. This includes:

- Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure the efficient provision of services.
- Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.
- Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider.

Care Coordination will be performed by the member of the Cedar Team (Licensed Clinician or Family Service Coordinator) that is most appropriate based upon the issue that is being addressed.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The electronic case management system described above will also be utilized to support the delivery of Care Coordination by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family.

**Scope of service****The service can be provided by the following provider types**☐ Behavioral Health Professionals or Specialists**Description**

Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.

Licensed clinicians are required to sign off on all Assessments and Family Care Plans/Action Plans. Depending on the clinical necessity, licensed clinicians may also:

- Provide and assist families in obtaining information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance plans, school-based services, faith based organizations, etc.
- Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider and payer. This also includes follow-up and consultation with the evaluator as needed.
- Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure engagement of services and supports.

☐ Nurse Practitioner☐ Nurse Care Coordinators☐ Nurses☐ Medical Specialists☐ Physicians☐ Physician's Assistants

- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☐ Other (specify)

Provider Type	Description
Family Service Coordinator	<p>Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.</p> <ul style="list-style-type: none"> <li>• Provide and assist families in obtaining information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance plans, school-based services, faith based organizations, etc.</li> <li>• Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider and payer. This also includes follow-up and consultation with the evaluator as needed.</li> <li>• Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure engagement of services and supports.</li> </ul>

## Health Promotion

### Definition

OVERARCHING STATEWIDE DEFINITION: Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Cedar HEALTH HOME SPECIFIC DEFINITION: Health Promotion assists children and families in implementing the Action Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child's condition(s), preventing the development of secondary or other chronic conditions, addressing family and child engagement, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s).

### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The electronic case management system described above will also be utilized to support the delivery of Health Promotion by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. See Care Coordination description above. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Health Promotion activities. This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

### Scope of service

#### The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists

#### Description

Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.

Behavioral Health Professionals or Specialists work with the family to:

- o assess the most pressing needs of the child and family;
- o identify triggers and patterns linked with problems;
- o set individual goals for the child/family in the areas of self-management and skill acquisition
- o help develop specific intervention strategies that they will be able to carry out in the home environment to work toward the established goals

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians

- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

#### Provider Type

Family Service Coordinator

#### Description

Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.

Family Service Coordinators work with the family to:

- o Assist in assessing the most pressing needs of the child and family;
- o Assist in identifying triggers and patterns linked with problems;
- o Assist in setting individual goals for the child/family in the areas of self-management and skill acquisition
- o Assist in helping develop specific intervention strategies that they will be able to carry out in the home environment to work toward the established goals

### Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

#### Definition

OVERARCHING STATEWIDE DEFINITION: Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back in to the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. Cedar HEALTH HOME SPECIFIC DEFINITION: Transitional Care will be provided by the Cedar Team to both existing clients who have been hospitalized or placed in other non-community settings as well as newly identified clients who are entering the community. Cedar Family Centers are not required to establish written protocols on the care transition process with hospitals or other institutions. The Cedar Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). These service include providing access to and the coordination of long term services and supports. Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into School based services and pediatric services to adult services. Cedar Family Centers have and continue to improve on their relationships with the health plan providers of their children and families in order to facilitate effective transitional care.

#### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The electronic case management system described above will also be utilized to support the delivery of comprehensive transitional care by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating comprehensive transitional care activities. This information will be provided in hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

#### Scope of service

#### The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists

#### Description

Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.

Depending on the clinical necessity, licensed clinicians will collaborate with all parties involved with a family including the inpatient facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions and includes transition from pediatric services to adult services.

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians

- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

Provider Type	Description
Family Service Coordinator	<p>Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.</p> <p>Collaborate with all parties involved with a family including the inpatient facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions and includes transition from pediatric services to adult services.</p>

### Individual and Family Support (which includes authorized representatives)

#### Definition

OVERARCHING STATEWIDE DEFINITION: Individual and family support services assist individuals to accessing services that will reduce barriers to treatment and improve health outcomes. Family involvement may vary based on the age, ability, and needs of each individual. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills. Cedar HEALTH HOME SPECIFIC DEFINITION: The Cedar Team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on Children with Special Health Care Needs and include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services. These services also includes providing access to and the coordination of long term services and supports. The Cedar Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the Cedar Team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries.

#### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The electronic case management system described above will also be utilized to support the delivery of individual/family support by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating individual/family support activities. This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

#### Scope of service

#### The service can be provided by the following provider types

<input type="checkbox"/> Behavioral Health Professionals or Specialists	<p><b>Description</b></p> <p>Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.</p> <p>Depending on the clinical necessity, licensed clinicians will 1) provide assistance to the family in accessing and coordinating services (these services include the full range of services that impact on Children with Special Health Care Needs and their families and may include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services), 2) actively integrate the full range of services into a comprehensive Family Care Plan, and 3) at the family's request, play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries.</p>
<input type="checkbox"/> Nurse Practitioner	
<input type="checkbox"/> Nurse Care Coordinators	
<input type="checkbox"/> Nurses	
<input type="checkbox"/> Medical Specialists	
<input type="checkbox"/> Physicians	
<input type="checkbox"/> Physician's Assistants	

- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☐ Other (specify)

Provider Type	Description
Family Service Coordinator	<p>Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.</p> <p>Family Service Coordinators will 1) provide assistance to the family in accessing and coordinating services (these services include the full range of services that impact on Children with Special Health Care Needs and their families and may include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services), 2) actively integrate the full range of services into a comprehensive Family Care Plan, and 3) at the family's request, play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries.</p>

## Referral to Community and Social Support Services

### Definition

OVERARCHING STATEWIDE DEFINITION: Referrals to community and social support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical behavioral, educational, and social and community issues. Cedar HEALTH HOME SPECIFIC DEFINITION: Referral to Community and Social Support Services will be provided by members of the Cedar Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options including the family's health coverage, school-based services, faith based organizations, etc. This includes providing access to and the coordination of long term services and supports. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the Cedar Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families.

### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The electronic case management system described above will also be utilized to support the delivery of referral services by providing easy and immediate access to comprehensive information and tools (such as the Individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the Cedar Team in meeting the needs of each child and family. In addition Cedar Family Centers provide their staff with access to a wide range of resource/educational material(s) in multiple formats for use in supplementing and facilitating Referral to Community and Social Support activities. This information will be provided in a hard copy or electronic format that is most appropriate for the child and families use, including multiple languages.

### Scope of service

### The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists

### Description

Master's degree in Social Work or Psychology preferred. Must have one of the following professional licensures -LCSW, LICSW, LMHC, LMFT, Master's degree Level RN, PhD. Independently licensed clinician that is licensed by the State of RI Dept of Health, demonstrating competency in strength-based family centered practice, needs assessment and care plan development, medical complexities, Autism Spectrum Disorders, behavioral health, and/or Developmental disabilities.

Depending on the clinical necessity, licensed clinicians will 1) refer to Community and Social Support Services which will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance payers, school-based services, faith based organizations, etc., 2) whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community and 3) emphasize the use of informal, natural community supports as a primary strategy to assist children and families.

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

**Provider Type****Description**

Family Service Coordinator

Family Service Coordinator demonstrating competency in strength-based family centered practice, community resources available to children and families, medical complexities and or legal issues experienced by families of children with special health care needs.

Family Service Coordinators will 1) refer to Community and Social Support Services which will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance payers, school-based services, faith based organizations, etc., 2) whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community, and 3) emphasize the use of informal, natural community supports as a primary strategy to assist children and families.

## Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

### Package Header

Package ID	RI2018MS00070	SPA ID	RI-18-0009
Submission Type	Official	Initial Submission Date	8/7/2018
Approval Date	10/17/2018	Effective Date	7/1/2018
Superseded SPA ID	N/A		

### Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Families access a Cedar through self-referral or other referral sources. When these sources initiate the referral, the Cedar must contact family within 10 calendar days. A family may choose to use a Cedar for assessment of needs, referral, and care coordination. The Cedar staff will assist the family in identifying and coordinating services and supports and to support efforts to gain access to needed services and to track receipt of services. A Needs Assessment must be completed within 45 calendar days of initial request, or sooner, based upon the urgency of the child and family's needs. The initial Family Care Plan (FCP) must be completed within 45 calendar days from referral. FCP must be reviewed and signed by an independently licensed clinician and may be in place for up to 12 months. If needed, the Cedar will work with family to develop individualized Crisis Support Plan which includes individuals or agencies for the family to contact in the event of a specific crisis (e.g., child's PCP, local mental health center) and actions to take to ensure safety of child and family. The plan should be reviewed and updated as needed. From first contact family members are expected to be fully informed about the role of the Cedar and knowledgeable about transition/discharge planning from the start of services. Discharge planning may include meetings with families and other involved parties in order to ensure achievement of Family Care Plan goals. Any one of the following criterion may be used to determine the child's readiness for discharge: 1) the goals and actions established in the Family Care Plan have been successfully met and the family is not in need of additional Cedar services, 2) the family has been linked to services and supports identified in the Family Care Plan, 3) the family, guardian, or child withdraws consent for Cedar services, 4) the child has lost Medicaid eligibility or 5) it has been determined that an administrative discharge is needed.

Name	Date Created
Cedar Health Home Patient Flow_final	8/7/2018 2:05 PM EDT
Cedar Health Home Patient Flow - Managed Care	9/26/2018 2:49 PM EDT



# Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

## Package Header

Package ID	RI2018MS00070	SPA ID	RI-18-0009
Submission Type	Official	Initial Submission Date	8/7/2018
Approval Date	10/17/2018	Effective Date	7/1/2018
Superseded SPA ID	N/A		

## Monitoring

**Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates**

The State will annually perform an assessment of cost savings using a pre/post-period comparison of Cedar health home clients. Savings calculations will be based on data garnered from the MMIS, encounter data from Health Plans, encounter data submitted the Health Home providers, and any other applicable data available from the RI Data Warehouse.

**Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)**

The state will phase-in the use of HIT to support health home services. Initially, providers will be supported in their delivery of health home services through data profiles supplied by Medicaid managed care plans for the 60% of the health home-eligible Cedar population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below.

- 1) Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date, Last ER Visit Primary Diagnosis, #Urgent Care Visits).
- 2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site.
- 3) Prescription Drug information
- 4) Behavioral Health Utilization

In addition Cedar Health Homes also accesses the RI KIDSNET Child Health Information System which provides access to information vital to the provision of Comprehensive Care Management. This information includes: Blood Lead levels, Immunizations, Newborn Developmental Assessment, Hearing Assessment, WIC and Early Intervention participation.

Cedar Health Homes will also offer to enroll all clients into "CurrentCare" RI's electronic health information exchange.

## Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00070 | RI-18-0009 | CEDAR Health Homes

### Package Header

**Package ID** RI2018MS00070

**SPA ID** RI-18-0009

**Submission Type** Official

**Initial Submission Date** 8/7/2018

**Approval Date** 10/17/2018

**Effective Date** 7/1/2018

**Superseded SPA ID** N/A

### Quality Measurement and Evaluation

- ☐ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- ☐ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- ☐ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- ☐ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.


*This view was generated on 1/17/2019 4:01 PM EST*

Records / Submission Packages

**RI - Submission Package - RI2018MS00060 - (RI-18-0006) - Health Homes**[Summary](#) [Reviewable Units](#) [Versions](#) [Correspondence Log](#) [Approval Notice](#) [News](#) [Related Actions](#)

CMS-10434 OMB 0938-1188

**Package Information**

<b>Package ID</b>	RI2018MS00060	<b>Submission Type</b>	Official
<b>Program Name</b>	Migrated_HH.CONVERTED Rhode Island-2 Health Home Services	<b>State</b>	RI
<b>SPA ID</b>	RI-18-0006	<b>Region</b>	Boston, MA
<b>Version Number</b>	2	<b>Package Status</b>	Approved
<b>Submitted By</b>	Melody Lawrence	<b>Submission Date</b>	6/29/2018
<b>Package Disposition</b>		<b>Approval Date</b>	9/27/2018 7:23 AM EDT


Records / Submission Packages

# RI - Submission Package - RI2018MS0006O - (RI-18-0006) - Health Homes

Summary   Reviewable Units   Versions   Correspondence Log   Approval Notice   News   Related Actions

CMS-10434 OMB 0938-1188

## Package Information

<b>Package ID</b>	RI2018MS0006O	<b>Submission Type</b>	Official
<b>Program Name</b>	Migrated_HH.CONVERTED Rhode Island-2 Health Home Services	<b>State</b>	RI
<b>SPA ID</b>	RI-18-0006	<b>Region</b>	Boston, MA
<b>Version Number</b>	2	<b>Package Status</b>	Approved
<b>Submitted By</b>	Melody Lawrence	<b>Submission Date</b>	6/29/2018
<b>Package Disposition</b>		<b>Approval Date</b>	9/27/2018 7:23 AM EDT

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	N/A
Superseded SPA ID	N/A		

### State Information

State/Territory Name:	Rhode Island	Medicaid Agency Name:	Executive Office of Health and Human Services
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### Submission Component

<input checked="" type="radio"/> State Plan Amendment	<input checked="" type="radio"/> Medicaid
	<input type="radio"/> CHIP

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	N/A
Superseded SPA ID	N/A		

## SPA ID and Effective Date

SPA ID RI-18-0006

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	6/1/2018	RI-16-0002-X
Health Homes Geographic Limitations	6/1/2018	RI-16-0002-X
Health Homes Population and Enrollment Criteria	6/1/2018	RI-16-0002-X
Health Homes Providers	6/1/2018	RI-16-0002-X
Health Homes Service Delivery Systems	6/1/2018	RI-16-0002-X
Health Homes Payment Methodologies	6/1/2018	RI-16-0002-X
Health Homes Services	6/1/2018	RI-16-0002-X
Health Homes Monitoring, Quality Measurement and Evaluation	6/1/2018	RI-16-0002-X

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_IHH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	N/A
Superseded SPA ID	N/A		

## Executive Summary

**Summary Description Including Goals and Objectives.** Integrated Health Home (IHH) - Rhode Island's Integrated Health Home is built upon the evidence-based practices of the patient-centered medical home (PCMH) model. IHH coordinates care for persons with Severe Mental Illness (SMI) and builds linkages with and among behavioral healthcare providers, primary care, specialty medical providers, and community and social supports. In addition to IHH services, EOHHS anticipates that 10% of the SMI population deemed eligible for IHH will meet the eligibility threshold for a supplemental set of services provided under Assertive Community Treatment (ACT).

The goals of IHH and ACT are to more effectively address the complex needs of persons with severe mental illness and co-occurring chronic conditions. IHH is provided to community-based individuals by a team of professional and paraprofessional mental health staff in accordance with an approved treatment plan to ensure the member's stability, improved medical outcomes, and reduced reliance on more restrictive services, such as the emergency department, inpatient medical-surgical and psychiatric care. IHH teams coordinate care and ensure that medically necessary interventions are provided to help the member manage the symptoms of their illness. The IHH team assists members; their providers; and their natural community supports to address social determinants affecting the member's health and well-being. Members receive assistance accessing medical, social, educational, and vocational services, as necessary.

ACT is a comprehensive and complementary set of services designed to meet all of a members' needs in a community setting. A multi-disciplinary team provides the member enrolled in ACT with mental health outpatient services, care coordination, peer support, psychopharmacology, substance use disorder counseling, vocational training, and care management, with the goal of increasing community tenure. ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation programs—that is the role of the IHH staff layered onto the ACT teams. The ACT team delivers integrated clinical treatment, rehabilitation, and other supportive services in community locations. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for members. ACT teams are available to provide necessary services 24 hours a day, seven days a week, 365 days a year. Research has shown that ACT services are successful in achieving outcomes and increasing community tenure for individuals with SMI and complex needs. Rhode Island's Integrated Health Home provides for ACT services for those identified to be in need, as established in a standardized level of care/functionality assessment. Members with a DLA score of 3.0 and under will be eligible for ACT. ACT programs will be reviewed by BHDDH using the Tool for Measurement of Assertive Community Treatment (TMACT) fidelity scale. EOHHS, through a collaboration with the MCOs and BHDDH, will monitor the clients receiving ACT as a subset of the IHH population.

Effective June 1, 2018, Rhode Island is proposing to remove the ten percent (10%) quality withhold from the IHH/ACT payment methodology to avoid potential disruptions in the provider network. The removal of the 10% withhold will not impede EOHHS' efforts to promote data as a quality improvement tool. EOHHS will monitor the providers' performances, and those not meeting performance targets will be required to submit corrective action plans. EOHHS will monitor compliance with corrective action plans by calculating the measures that fell short of the targets on a quarterly basis. If providers do not show improvement, measures will be added to future year measures. Results will be shared with the CMHOs and each Managed Care Organization to improve provider performance with MCO collaboration.

## Federal Budget Impact and Statute/Regulation Citation

## Federal Budget Impact

Federal Fiscal Year	Amount
First 2018	\$0



	Federal Fiscal Year	Amount
Second	2019	\$0

Federal Statute / Regulation Citation  
 Section 2703 of the Patient Protection and Affordable Care of 2010

### Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID RI2018MS00060  
Submission Type Official  
Approval Date 9/27/2018  
Superseded SPA ID N/A

SPA ID RI-18-0006  
Initial Submission Date 6/29/2018  
Effective Date N/A

### Governor's Office Review

- ☐ No comment
- ☐ Comments received
- ☐ No response within 45 days
- ☒ Other

**Describe** This amendment has not been reviewed specifically with the Governor's Office. Under the Rhode Island Medicaid State Plan, the Governor has elected not to review the details of state plan materials. However, in accordance with Rhode Island law and practice, the Governor is kept apprised of major changes in the state plan.

## Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	N/A
Superseded SPA ID	N/A		

## Name of Health Homes Program

Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

Indicate whether public comment was solicited with respect to this submission.

- ☐ Public notice was not federally required and comment was not solicited
- ☐ Public notice was not federally required, but comment was solicited
- ☒ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☒ Email to Electronic Mailing List or Similar Mechanism

Date of Email or other electronic notification: May 29, 2018

Description of mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used: Public notice was electronically emailed to EOHHS' list of interested parties. Such mailing list includes, but is not limited to providers, advocates, and other state agencies.

☒ Website Notice

Select the type of website

☒ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: May 29, 2018

Website URL: <http://www.eohhs.ri.gov/ReferenceCenter/MedicaidStatePlanand1115Walver/SPAand1115WalverChanges.aspx>

☐ Website for State Regulations

☐ Other

☐ Public Hearing or Meeting

☐ Other method

## Upload copies of public notices and other documents used

Name

Date Created

IHHACT - Public Notice 5.29.18

6/29/2018 12:55 PM EDT

Upload with this application a written summary of public comments received (optional)

Name

Date Created

No items available

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

## Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID RI2018MS00060  
Submission Type Official  
Approval Date 9/27/2018  
Superseded SPA ID N/A

SPA ID RI-18-0006  
Initial Submission Date 6/29/2018  
Effective Date N/A

## Name of Health Homes Program

Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

One or more Indian health programs or Urban Indian  
Organizations furnish health care services in this state

☒ Yes  
☐ No

This state plan amendment is likely to have a direct effect on  
Indians, Indian health programs or Urban Indian Organizations

☒ Yes  
☐ No

☒ The state has solicited  
advice from Indian Health  
Programs and/or Urban Indian  
Organizations, as required by  
section 1902(a)(73) of the Social  
Security Act, prior to submission  
of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this  
submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

☒ All Indian Health Programs

Date of solicitation/consultation:

5/29/2018

Method of solicitation/consultation:

Tribal notification letter was sent to the Narragansett Indian Health  
Center 5/29/18. Not comments or questions were received.

☐ All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about  
such consultation below:

☐ All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including  
any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were  
held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's  
responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how  
the state incorporated them into the design of its program.

Name

Tribal Notice IHH.ACT\_5.29.18

Date Created

6/29/2018 12:56 PM EDT

Indicate the key issues raised (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

## Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID RI2018MS00060  
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Effective Date N/A

### SAMHSA Consultation

#### Name of Health Homes Program

Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

#### Date of consultation

4/21/2011

☒ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

## Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

### Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

#### Name of Health Homes Program

Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The full integration of clients' medical and behavioral benefits into managed care creates new opportunities for further clinical integration across the continuum of care. This integration will allow integrated health homes (IHH) greater capacity to work with clients across all levels of care in order to achieve substantial clinical improvement. Services provided through IHHs and Assertive Community Treatment (ACT) are the fixed points of responsibility to coordinate and ensure the delivery of person-centered care, provide timely post-discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist, and behavioral health care. Emphasis is placed on the monitoring of chronic conditions, preventative and educational services focused on self-care, wellness, and recovery.

This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. These outcomes are achieved by adopting a whole-person approach to the consumer's needs and addressing the consumer's primary medical, specialist, and behavioral health care needs; and by providing the following timely and comprehensive services:

- Comprehensive Care Management;
- Care Coordination/Health Promotion;
- Comprehensive Transitional Care;
- Individual/Family Support Services; and
- Chronic Condition Management/Population Management.

Clients eligible for IHH services will meet diagnostic and functional criteria established by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The required diagnoses are as follows:

- Schizophrenia
- Schizoaffective Disorder
- Schizoid Personality Disorder
- Bipolar Disorder
- Major Depressive Disorder, recurrent
- Obsessive-Compulsive Disorder
- Borderline Personality Disorder
- Delusional Disorder
- Psychotic Disorder

Effective June 1, 2018, Rhode Island is proposing to remove the ten percent (10%) quality withhold from the IHH/ACT payment methodology to avoid potential disruptions in the provider network. The removal of the 10% withhold will not impede EOHHS' efforts to promote data as a quality improvement tool. EOHHS will monitor the providers' performances, and those not meeting performance targets will be required to submit corrective action plans. EOHHS will monitor compliance with corrective action plans by calculating the measures that fell short of the targets on a quarterly basis. If providers do not show improvement, measures will be added to future year measures. Results will be shared with the CMHOS and each Managed Care Organization to improve provider performance with MCO collaboration.

### General Assurances

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.



- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

## Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | RIZ018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID RIZ018MS00060

SPA ID RI-18-0006

Submission Type Official

Initial Submission Date 6/29/2018

Approval Date 9/27/2018

Effective Date 6/1/2018

Superseded SPA ID RI-16-0002-X

System-Derived

- ☒ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☐ Health Homes services will be provided in a geographic phased-in approach

## Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID RI2018MS00060  
Submission Type Official  
Approval Date 9/27/2018  
Superseded SPA ID RI-16-0002-X  
System-Derived

SPA ID RI-18-0006  
Initial Submission Date 6/29/2018  
Effective Date 6/1/2018

### Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☒ Medically Needy Eligibility Groups

#### Mandatory Medically Needy

☒ Medically Needy Pregnant Women

☒ Medically Needy Children under Age 18

#### Optional Medically Needy (select the groups included in the population)

##### Families and Adults

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

##### Aged, Blind and Disabled

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

## Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID RI2018MS00060  
Submission Type Official  
Approval Date 9/27/2018  
Superseded SPA ID RI-16-0002-X  
System-Derived

SPA ID RI-18-0006  
Initial Submission Date 6/29/2018  
Effective Date- 6/1/2018

## Population Criteria

The state elects to offer Health Homes services to individuals with

- ☐ Two or more chronic conditions
- ☐ One chronic condition and the risk of developing another
- ☒ One serious and persistent mental health condition

## Specify the criteria for a serious and persistent mental health condition

Previously Health Home services were available to both individuals with SPMI and SMI as long as the center determined there was a need. BHDDH decided to be more prescriptive in eligibility for the bifurcated levels of service based on illness acuity. Therefore the following eligibility requirements were adopted:

Clients eligible for IHH services will meet diagnostic and functional criteria established by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The required diagnoses are as follows:

- Schizophrenia
- Schizoaffective Disorder
- Schizoid Personality Disorder
- Bipolar Disorder
- Major Depressive Disorder, recurrent
- Obsessive-Compulsive Disorder
- Borderline Personality Disorder
- Delusional Disorder
- Psychotic Disorder

Members will qualify for IHH and ACT based, in part on their score on the Daily Living Assessment of Functioning (DLA). Based on material disseminated at the DLA training in November 2015, the average DLA scores are interpreted as follows:

- 5.1-6.0- Mild Impairments, minimal interruption in recovery
- 4.1-5.0-Moderate Impairments in functioning
- 3.1-4.0-Serious Impairment in functioning
- 2.1-3.0-Severe Impairment in functioning
- 2.0-Extremely severe Impairments in functioning

Along with the established diagnostic categories, BHDDH has established the following guidelines for program assignment based on the client's DLA score:

- <3.0 - ACT
- >3.0-5.0 - IHH
- >5.0 - Outpatient

## Health Homes Population and Enrollment Criteria

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## Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- ☐ Opt-In to Health Homes provider
- ☒ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

## Describe the process used

Providers must complete an enrollment form before enrollment is entered into the BHDDH portal. The member or the member's authorized representative must sign the form. Every six (6) months, providers must attest to the fact that an enrollment form was completed for all members. Individuals assigned to a health home will be notified by the state via U.S. mail and other methods as necessary. The provider must retain the enrollment form in the member's record. The provider must also attach a roster of all IHH and ACT enrollees to each attestation form. BHDDH, EOHHS, and the MCOs reserve the right to request the enrollment form at any time.

Members will be determined eligible for IHH or ACT services based on the following criteria:

Members will qualify for IHH and ACT based, in part on their score on the Daily Living Assessment of Functioning (DLA). Average DLA scores are interpreted as follows:

- 5.1-6.0- Mild Impairments, minimal interruption in recovery
- 4.1-5.0- Moderate Impairments in functioning
- 3.1-4.0- Serious Impairment in functioning
- 2.1-3.0- Severe Impairment in functioning
- 2.0- Extremely severe impairments in functioning

Along with the established diagnostic categories, BHDDH has established the following guidelines for program assignment

<3.0 - ACT

>3.0-5.0 - IHH

Individuals eligible for health home services but not currently engaged with an IHH may be identified through data provided by Medicaid managed care organizations (MCOs) and other information from the state's Medicaid data warehouse. New members will be referred to a provider and assigned to IHH or ACT after they have met the diagnostic criteria and the provider has submitted a completed DLA to BHDDH. EOHHS and BHDDH reserve the right to review these documents at any time.

☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.

Name	Date Created
Medicaid redesign IHH and ACT enrollment form	6/29/2018 1:01 PM EDT



## Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

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### Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards--

- ☐ Physicians
- ☐ Clinical Practices or Clinical Group Practices
- ☐ Rural Health Clinics
- ☐ Community Health Centers
- ☒ Community Mental Health Centers

#### Describe the Provider Qualifications and Standards

CMHCs must be licensed as Community Mental Health Centers by BHDDH, certified as Health Home providers by BHDDH and currently providing Health Home services to the SMI population.

- ☐ Home Health Agencies
- ☐ Case Management Agencies
- ☐ Community/Behavioral Health Agencies
- ☐ Federally Qualified Health Centers (FQHC)
- ☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

## Health Homes Providers

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## Provider Infrastructure

## Describe the infrastructure of provider arrangements for Health Home Services

Rhode Island has six Community Mental Health Organizations (CMHOs), which along with two other providers of specialty mental health services form a statewide, fully integrated, mental health delivery system, providing a comprehensive range of services to clients. All CMHOs and two specialty providers (Fellowship Health Resources, Inc. and Riverwood Mental Health Services) are licensed by the state under the authority of Rhode Island General Laws and operate in accordance with Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The six CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, will serve as designated providers of CMHO health home services. The six CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, represent the only entities that would meet eligibility requirements as a CMHO health home. Each CMHO health home is responsible for establishing an integrated service network statewide for coordinating service provision. CMHO health homes will have agreements, memorandums of understanding, and linkages with other health care providers, in-patient settings and long-term care settings that specify requirements for the establishment of coordinating comprehensive care.

The health home teams consist of individuals with expertise in several areas, any team member operating within his or her scope of practice, area of expertise and role or function on a health home team, may be called upon to coordinate care as necessary for an individual, (i.e., the bio-psychosocial assessment can only be conducted as described under Care Management; however, a community support professional operating in the role of a hospital liaison may provide transitional care, health promotion and individual and family support services, as an example).

Standards for CMHO health home providers specify that each health home indicate how each provider will: structure team composition and member roles in CMHOs to achieve health home objectives and outcomes; coordinate with primary care (which could include co-location, embedded services, or the implementation of referral and follow-up procedures outlined in memoranda of understanding); formalize referral agreements with hospitals for comprehensive transitional care, and carry out health promotion activities.

## Health Homes Providers

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## Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

## Description

CMHOs will participate in a variety of learning supports, up to and including learning collaboratives (which are not mandatory), designed to instruct CMHOs to operate as health homes (HH) and provide care using a whole-person approach that integrates behavioral health, primary care and other needed services and supports. The following components will be addressed: Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HH services; Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines, preventive and health promotion services, including prevention of mental illness and substance use disorders, mental health and substance abuse services, comprehensive care management, care coordination, and transitional care across settings (including appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care); Coordinate and provide access to chronic disease management, including self-management support to individuals and their families, individual and family supports, including referral to community, social support, and recovery services, long-term care supports and services; Develop a person-centered-treatment plan for each individual that coordinates and integrates all of clients' clinical and non-clinical health-care related needs and services; Demonstrate capacity to use HIT to link services, facilitate communication among team members and between the HH team and individual and family caregivers, and provide feedback to practices, and; Establish a continuous quality improvement program to collect and report on data that facilitates an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.



## Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | RI2D18MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

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## Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

## Comprehensive Care Management

The IHH and ACT shall provide evidence of compliance with the following:

1. Service capacity and team composition; roles and responsibilities meet staffing requirements.
2. A comprehensive and culturally appropriate health assessment is used that yields both subjective and objective findings regarding the consumer's health needs.
3. The consumer's treatment plan clearly identifies primary, specialty, community networks and supports to address identified needs; along with family members and other supports involved in the consumer's care.
4. A consumer's treatment plan reflects the consumer's engagement level in goal setting, issue identification, self-management action, and the interventions to support self-management efforts to maintain health and wellness.
5. Service coordination activities use treatment guidelines that establish integrated clinical care pathways for health teams to provide organized and efficient care coordination across risk levels or health conditions.
6. The Program functions as the fixed point of responsibility for engaging and retaining consumers in care and monitoring individual and population health status to determine adherence or variance from recommended treatment guidelines.
7. Routine/periodic reassessment, using the Daily Living Activities Scale (DLA), conducted every 6 months at a minimum, to include reassessment of the care management process and the consumer's progress towards meeting clinical and person-centered health action plan goals.
8. The Program assumes primary responsibility for psychotropic medications, including administration; documentation of non-psychotropic medications prescribed by physicians and any medication adherence, side effects, issues etc.
9. The Program uses peer supports (certified Peer Recovery Specialists) and self-care programs to increase the consumer's knowledge about their health care conditions and to improve adherence to prevention and treatment activities.
10. Evidence that the outcome and evaluation tools being used by the health care team uses quality metrics, including assessment and survey results and utilization of services to monitor and evaluate the impact of interventions.

## Care Coordination and Health Promotion

The medical record shall provide evidence that:

1. Each consumer on the Program's team has a dedicated case manager who has overall responsibility and accountability for coordinating all aspects of the consumer's care.
2. A Program has a relationship with the community agencies in its local area. To that end it can provide evidence that the case managers can converse with these agencies on an as-needed basis when there are changes in a consumer's condition.
3. A Program facilitates collaboration through the establishment of relationships with all members of consumer's interdisciplinary health team.
4. Policies, procedures and accountabilities (contractual or memos of understanding agreements) have been developed to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, long-term services and supports and community-based organizations.
5. A psychiatrist or Advanced Practice Registered Nurse (APRN) /Nurse Practitioner provides medical leadership to the implementation and coordination of program's activities by developing and maintaining working relationships with primary and specialty care providers including various inpatient and long-term care facilities.
6. Protocol has been developed for priority appointments for Program's consumers to behavioral health providers and services, and within the Program's provider network to avoid unnecessary or inappropriate utilization of emergency room, inpatient hospital and institutional services.
7. The Program's provider has a system to track and share consumer's patient care information and care needs across providers and to monitor consumer's outcomes and initiate changes in care, as necessary, to address consumer needs.
8. 24 hours/seven days a week availability to provide information/emergency consultation services to the consumer.

## Comprehensive Transitional Care

The consumer's medical record shall provide evidence that:

1. A Program's case manager is an active participant in all phases of care transition, including timely access to follow-up care and post-hospital discharge (see metrics).
2. The Program's provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, residential/rehabilitation settings, and community-based services, to help ensure coordinated, safe transitions in care.
3. A notification system is in place with Managed Care Organizations to notify the Programs of a consumer's admission and/or discharge from an emergency room, inpatient unit, nursing home or residential/rehabilitation facility.

4. The Program collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the consumer's ability to self-manage care and live safely in the community.
5. Care coordination is used when transitioning an individual from jail/prison into the community.

Individual and Family Support Services

The consumer's medical record shall:

1. Incorporate, through the consumer's treatment plan, the consumer and family preferences, education, support for self-management, self-help, recovery, and other resources as needed to implement the consumer's health action goals.
2. Identify and refer to resources that support the consumer in attaining the highest level of health and functioning in their families and in the community, including ensuring transportation to and from medically necessary services.
3. Demonstrate communication and information shared with consumers and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Chronic Condition Management and Population Management

The consumer's medical record shall:

1. Identify available community-based resources discussed with consumers and evidence of actively managed appropriate referrals, demonstrate advocating for access to care and services, and include evidence of the provision of coaching for consumers to engage in self-care and follow-up with required services.
2. Reflect policies, procedures, and accountabilities (through contractual or memos of understanding, affiliation agreements or quality service agreements) to support effective collaboration with community-based resources, which clearly define roles and responsibilities.

Name

Date Created

No items available

## Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☒ Fee for Service  
☐ PCCM  
☒ Risk Based Managed Care

The Health Plans will be a  
Designated Provider or part  
of a Team of Health Care  
Professionals

- ☒ Yes  
☐ No

Provide a summary of the contract language that you will impose  
on the Health Plans in order to deliver the Health Homes services

The language included in the contract between EOHHS and the MCOs addresses the goals of the program, patient eligibility, provider eligibility, descriptions of core functions and responsibilities of IHH/ACT providers, assessment and reporting requirements, descriptions of services, and MCO responsibilities. Managed Care contracts will also include a description of the payment arrangement between the state and the MCO. MCO responsibilities include contracting with HHs to serve their members, coordinating care with the member's use of other MCO covered services, referring other MCO members who meet the enrollment criteria to Health Homes, providing HH with reporting to facilitate the coordination of medical and behavioral health care, use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with Health Homes, oversight to ensure contract requirements are being met, assist the HHs with identifying necessary components of metric reporting, adhere to the reporting date requirements based on a reporting calendar, adhere to continuity of care requirements, including maintenance of relationships between members and treating providers (including beneficiaries transitioning into the managed care organization), holding the member harmless, and ensure that the HHs are submitting HIPAA compliant claims data for services delivered under the IHH and ACT bundles. For MCO enrollees active with IHH/ACT, the MCO will leverage the care management provided at the Health Home and will not duplicate services. The MCO will work collaboratively with Health Homes to ensure all the member's needs are met.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name

Date Created

No items available

The State intends to include the Health Home payments in the  
Health Plan capitation rate

- ☒ Yes  
☐ No

Assurances

☒ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification-a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☒ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☒ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

## Health Homes Payment Methodologies

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### Payment Methodology

The State's Health Homes payment methodology will contain the following features

☒ Fee for Service

☐ Individual Rates Per Service

☐ Per Member, Per Month Rates

☒ Comprehensive  
Methodology Included in the  
Plan

☒ Fee for Service Rates based on

☐ Severity of each individual's  
chronic conditions

☒ Capabilities of the team of  
health care professionals,  
designated provider, or health  
team

☐ Other

☐ Incentive Payment Reimbursement

Describe any variations in  
payment based on provider  
qualifications, individual care  
needs, or the intensity of the  
services provided

Per Diem Rate to CMHO for Integrated Health Home (IHH) and Assertive Community Treatment (ACT)

1. Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).
2. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations, and all other applicable state and local fire and safety codes and ordinances.
3. Providers must agree to contract and accept the rates paid by the Managed Care Organization as established with the Executive Office of Health and Human Service (EOHHS) and BHDDH as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.
4. Providers must be enrolled in the RI Medicaid Program, have a contract with the Managed Care Organizations and agree to meet all requirements, such as, timely access to care and matching beneficiaries service needs.
5. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.
6. The State will pay for services under this section on the basis of the methodology described in the section titled "Basis for IHH Methodology" of this document.
7. The amount of time allocated to IHH and ACT for any individual staff member is reflective of the actual time that staff member is expected to spend providing reimbursable IHH and ACT services to Medicaid recipients.
8. Providers are required to collect and submit complete encounter data for all IHH/ACT claims on a monthly basis utilizing standard Medicaid coding and units in an electronic format determined by EOHHS, BHDDH and Managed Care Organizations. The state will conduct an analysis of the data to develop recipient profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential adjustments to the case rate as well as for consideration of alternative payment methodologies. Analysis will be conducted at least annually.
9. The State assures that IHH and ACT services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.
10. The base rates were set as of January 1, 2016 and are described below.

Staffing Model and Rates for ACT  
ACT/High Acuity Team:  
12.75 FTE: y\_PKG\_1 Team Census

FTE = 35 Hour Work Week  
 Program Staff FTE Cost/FTE  
 Total Cost  
 Program Director (LCSW, LMHC, LMFT, LCPD, RN) 1 \$68,000 \$68,000  
 Registered Nurse 2 \$66,000  
 \$132,000  
 Master's Level Clinician 1 \$60,000  
 \$60,000  
 Vocational Specialist, Bachelor's level 1 \$44,000  
 \$44,000  
 Substance Abuse Specialist, Bachelor's level 2 \$44,000  
 \$88,000  
 CPST Specialist, Bachelor's level 4 \$41,000  
 \$164,000  
 Peer Specialist 1 \$41,000 \$41,000  
 Psychiatrist 0.75 \$230,000  
 \$172,500  
 Fringe at 30%  
 \$230,850  
 Total Salaries & Fringe  
 \$1,080,350

Indirect/Administrative Costs including: Rent, Utilities, Facility Maintenance, Program Supplies, Information Technology (EHR, Hardware, Phone), Data Collection (e.g. Use of RNL, Collection of Outcomes), Quality Improvement Staff, Health Information  
 Total Administrative and Operating Expense @52%  
 \$520,182  
 All Cost Total Annual  
 \$1,520,532  
 Base Rate (Monthly Unit)  
 \$1,267

Salaries are based on mean of RI Department of Labor Occupational Statistics

The following is a list of allowable services for ACT:

- A. Service Coordination/Case Management
- B. Crisis Assessment and Intervention
- C. Symptom Assessment and Management
- D. Medication Prescription, Administration, Monitoring and Documentation
- E. Dual Diagnosis Substance Use Disorder Services
- F. Work-Related Services
- G. Services to support activities of daily living in community-based settings
- H. Social/Interpersonal Relationship and Leisure-Time Skill Training
- I. Peer Support Services
- J. Other Support Services—Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including-but not limited to:
  - 1. Medical and dental services
  - 2. Safe, clean, affordable housing
  - 3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)
  - 4. Social service
  - 5. Transportation
  - 6. Legal advocacy and representation
- K. Education, Support, and Consultation to Clients' Families and Other Major Supports

#### 11. Basis for IHH Methodology for IHH:

The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. The process also included the development of a standard core IHH team composition and suggested caseload based on estimates of available staff hours and client need. Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.

Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire number of staff, cost and salaries for all positions for Health Homes of the agency. Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage the team to obtain the outcomes.

Staffing Model (per 200 clients):

Title

FTE

Master's Level Program Director

1

Registered Nurse  
 2  
 Hospital Liaison  
 1  
 CPST Specialist  
 5-6  
 Peer Specialist  
 1  
 Medical Assistant  
 1 (optional)

IHH  
 OCCUPANCY  
 v\_PKG\_1.0%  
 CLIENTS  
 200  
 Program  
 Staff:  
 Qualifications: FTE  
 Cost/FTE Total Cost

Master's Level Coordinator  
 1.0 \$78,817 \$78,817

Registered Nurse  
 2.0 \$81,500 \$163,000

Hospital Liaison 1.0  
 \$44,200 \$44,200

CPST Specialist BA  
 6.0 \$44,200 \$265,200

Peer Specialist 1.0  
 \$43,711.00 \$43,711.00

Medical Assistant  
 1.0 \$39,360 \$39,360

\$634,288

12.0  
 Fringe (included in base cost)  
 0

Total base staff cost  
 \$634,288

Total all staff cost  
 \$634,288

Total administration and operating at state average  
 59% \$374,230

Total all costs  
 \$1,008,518

PMPM  
 \$420.22

All CMHOs will be required to report to the MCOs and RI Medicaid on a quarterly basis on a set of required metrics. EOHHS and BHDDH support the importance of standardized reporting on outcome measures to ensure providers are increasing quality so clients make gains in overall health. Providers not meeting performance targets shall submit corrective action plans describing how full compliance will be accomplished. BHDDH and EOHHS will monitor progress and compliance with corrective action plans. If improvement is not detected, these measures will be added to the following year's measures.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☒ Tiered Rates based on

☒ Alternative models of payment, other than Fee for-Service or PMPM payments (describe below)

☐ Severity of each individual's chronic conditions

☒ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided**

Per Diem Rate to CMHO for Integrated Health Home (IHH) and Assertive Community Treatment (ACT)

1. Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).
2. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations, and all other applicable state and local fire and safety codes and ordinances.
3. Providers must agree to contract and accept the rates paid by the Managed Care Organization as established with the Executive Office of Health and Human Service (EOHHS) and BHDDH as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.
4. Providers must be enrolled in the RI Medicaid Program, have a contract with the Managed Care Organizations and agree to meet all requirements, such as, timely access to care and matching beneficiaries service needs.
5. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.
6. The State will pay for services under this section on the basis of the methodology described in the section titled "Basis for IHH Methodology" of this document.
7. The amount of time allocated to IHH and ACT for any individual staff member is reflective of the actual time that staff member is expected to spend providing reimbursable IHH and ACT services to



## Medicaid recipients.

8. Providers are required to collect and submit complete encounter data for all IHH/ACT claims on a monthly basis utilizing standard Medicaid coding and units in an electronic format determined by EOHHS, BHDDH and Managed Care Organizations. The state will conduct an analysis of the data to develop recipient profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential adjustments to the case rate as well as for consideration of alternative payment methodologies. Analysis will be conducted at least annually.

9. The State assures that IHH and ACT services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.

10. The base rates were set as of January 1, 2016 and are described below.

## Staffing Model and Rates for ACT

## ACT/High Acuity Team:

12.75 FTE; v\_PKG\_1 Team

Census

FTE = 35 Hour Work Week

Program Staff FTE Cost/FTE

Total Cost

Program Director (LICSW, LMHC,

LMFT, LCP, RN) 1 \$68,000

\$68,000

Registered Nurse 2 \$66,000

\$132,000

Master's Level Clinician 1

\$60,000

\$60,000

Vocational Specialist, Bachelor's

level 1 \$44,000

\$44,000

Substance Abuse Specialist,

Bachelor's level 2 \$44,000

\$88,000

CPST Specialist, Bachelor's level

4 \$41,000

\$164,000

Peer Specialist 1 \$41,000

\$41,000

Psychiatrist 0.75 \$230,000

\$172,500

Fringe at 30%

\$230,850

Total Salaries & Fringe

\$1,000,350

## Indirect/Administrative Costs

Including: Rent, Utilities, Facility

Maintenance, Program Supplies,

Information Technology (EHR,

Hardware, Phone), Data

Collection (e.g. Use of RNL,

Collection of Outcomes), Quality

Improvement Staff, Health  
Information  
Total Administrative and  
Operating Expense @52%  
\$520,182  
All Cost Total Annual  
\$1,520,532  
Base Rate (Monthly Unit)  
\$1,267

Salaries are based on mean of RI  
Department of Labor  
Occupational Statistics

The following is a list of  
allowable services for ACT:

- A. Service Coordination/Case Management
- B. Crisis Assessment and Intervention
- C. Symptom Assessment and Management
- D. Medication Prescription, Administration, Monitoring and Documentation
- E. Dual Diagnosis Substance Use Disorder Services
- F. Work-Related Services
- G. Services to support activities of daily living in community-based settings
- H. Social/Interpersonal Relationship and Leisure-Time Skill Training
- I. Peer Support Services
- J. Other Support Services—Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:
  - 1. Medical and dental services
  - 2. Safe, clean, affordable housing
  - 3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)
  - 4. Social service
  - 5. Transportation
  - 6. Legal advocacy and representation
  - K. Education, Support, and Consultation to Clients' Families and Other Major Supports

11. Basis for IHH Methodology for IHH:  
The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. The process also included the development of a standard core IHH team composition and suggested caseload based on estimates of available staff hours and client need. Flexibility is given to the providers for the costs of the

entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.

Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire number of staff, cost and salaries for all positions for Health Homes of the agency. Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage the team to obtain the outcomes.

Staffing Model (per 200 clients):

Title

FTE

Master's Level Program Director

1

Registered Nurse

2

Hospital Liaison

1

CPST Specialist

5-6

Peer Specialist

1

Medical Assistant

1 (optional)

IHH

OCCUPANCY

v\_PKG\_1.0%

CLIENTS

200

Program

Staff:

Qualifications: FTE

Cost/FTE Total Cost

Master's Level Coordinator

1.0 \$78,817 \$78,817

Registered Nurse

2.0 \$81,500 \$163,000

Hospital Liaison 1.0

\$44,200 \$44,200

CPST Specialist BA

6.0 \$44,200 \$265,200

Peer Specialist 1.0

\$43,711.00 \$43,711.00

Medical Assistant

1.0 \$39,360 \$39,360

\$634,288

12.0

Fringe (Included in base cost)

0

Total base staff cost

\$634,288

Total all staff cost  
\$634,288Total administration and  
operating at state average  
59% \$374,230Total all costs  
\$1,008,518PMPM  
\$420.22

All CMHOs will be required to report to the MCOs and RI Medicaid on a quarterly basis on a set of required metrics. EOHHS and BHDDH support the importance of standardized reporting on outcome measures to ensure providers are increasing quality so clients make gains in overall health. Providers not meeting performance targets shall submit corrective action plans describing how full compliance will be accomplished. BHDDH and EOHHS will monitor progress and compliance with corrective action plans. If improvement is not detected, these measures will be added to the following year's measures.

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

See response to above.

## Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HHLCONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

### Agency Rates

#### Describe the rates used

- ☐ FFS Rates included in plan
- ☒ Comprehensive methodology included in plan
- ☐ The agency rates are set as of the following date and are effective for services provided on or after that date

**Health Homes Payment Methodologies**

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

**Package Header**

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

**Rate Development****Provide a comprehensive description in the SPA of the manner in which rates were set**

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
  - the frequency with which the state will review the rates, and
  - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

**Comprehensive Description** See description of rate development above.

## Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS0006D | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID	RI2018MS0006D	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

## Assurances

☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

**Describe below how non-duplication of payment will be achieved** To avoid duplication of payment for similar services, the State has employed an on-line portal developed by Hewlett Packard Enterprises that validates the dates of enrollment in Health Home programs. Providers must enter client data into the on-line portal. If the client is already a client of another Health Home program, including Opiate Treatment Health Home or an Assertive Community Treatment program, the portal will give them an error message. This provides the State with assurances that duplicate programming and billing does not occur.

☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

## Optional Supporting Material Upload

Name

Date Created

No items available

## Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

### Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

#### Comprehensive Care Management

##### Definition

Comprehensive care management services are conducted with an individual and involve the identification, development and implementation of treatment plans that address the needs of the whole person. Family/Peer Supports can also be included in the process. The service involves the development of a treatment plan based on the completion of an assessment. Health Home staff will adjust treatment plans as changes in status and conditions dictate. A particular emphasis is the use of the multi-disciplinary teams including medical personnel who may or may not be directly employed by the provider of the health home. The recipient of comprehensive care management is an individual with complex physical and behavioral health needs.

##### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The State implemented Current Care via the State Health Information Exchange (RIQH). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQH and is being purchased through the SIM initiative to increase the capacity of CMHCs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

##### Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

##### Description

Qualified Behavioral Health Specialists will conduct initial bio-psychosocial assessments and work with patients and other team members to develop care plans. Case managers will be responsible for ensuring adherence to the plan, engaging family members and other supports, and monitoring outcomes, and thus have primary responsibility for this activity. Case managers will assist patients in accessing other specialized care, encouraging patients to keep appointments and follow through with care recommendations.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ Nurse Practitioner

☐ Nurse Care Coordinators



☒ Nurses

**Description**

As part of the multi-disciplinary team, nurses will assist in the development of the care plan. Nurses will regularly coordinate with other healthcare providers and establish routine communications. Nurses will continue to assess patients throughout treatment and monitor progress in achieving health care plan goals.

☐ Medical Specialists

☒ Physicians

**Description**

Physicians review assessments and treatment plans and meet as necessary with Health Home participants. Physicians are central to the creation of the care plan and lead teams to identify need for specialized care. Physicians prescribe and monitor medication and are available to consult with all other providers.

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☐ Other (specify)

**Care Coordination**

**Definition**

The IHH team supports its consumers as they participate in managing the care they receive. Interventions provided under IHH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills, and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms;
- Provide health education, counseling, and symptom management to enable client to be knowledgeable in the oversight of chronic medical illness as advised by the client's primary/specialty medical team;
- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;
- Assisting the client in locating and effectively utilizing all necessary medical, social, and psychiatric community services;
- Assisting in the development and implementation of a plan for assuring client income/maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage their psychiatric and medical symptoms to live in the community. This includes:
  - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling;
  - Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services (e.g. payeehip etc.).
  - Develop skills related to reliable transportation (help obtain driver's license, arrange for cabs, finds rides).
  - Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client social and interpersonal activities in community settings) e.g. plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including direct support and coaching.
  - Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:
    - Support the client to consistently adhere to their medication regimens, especially for clients who are unable to engage due to symptom impairment issues.
    - Accompanying clients to and assisting them at pharmacies to obtain medications.
    - Accompany consumers to medical appointments, facilitate medical follow up.
    - Provide direct support and coaching to help clients socialize - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

The IHH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps IHHs improve their care delivery system, to the benefit of each IHH clients receiving care.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHCs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

## Scope of service-

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

## Description

The position with primary responsibility for this service will be case managers. Case managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: Assessing support and service needed to ensure the continuing availability of required services; Assistance in accessing necessary health care and follow up care and planning for any recommendations; Assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing; Conducting outreach to family members and significant others in order to maintain individuals connection to services, and expand social network; Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated; and; Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

☐ Nurse Practitioner☐ Nurse Care Coordinators☐ Nurses☐ Medical Specialists☐ Physicians☐ Physician's Assistants☐ Pharmacists☐ Social Workers☐ Doctors of Chiropractic☐ Licensed Complementary and alternative Medicine Practitioners☐ Dieticians☐ Nutritionists☐ Other (specify)

## Health Promotion

## Definition

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised as necessary, and advocate for client rights and preferences. The case manager will collaborate with primary and specialty care providers as required. Additionally, the case manager will provide medical education to the client (e.g. educating through written materials, etc.).

The IHH team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with treatment plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include services such as smoking cessation, nutrition, and stress management. The Managed Care Organizations (MCOs) and

CMHOs will meet regularly to review performance metrics and to collaborate on improvement plans. The IHH will coordinate with the client's Primary Care Physician (PCP). These additional plans will be incorporated into the patient's overall treatment plan.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The State implemented Current Care via the State Health Information Exchange (RIQH). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQH and is being purchased through the SIM initiative to increase the capacity of CMHOs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

**Scope of service**

**The service can be provided by the following provider types**

☒ Behavioral Health Professionals or Specialists

**Description**

Master's level team leaders will be responsible for the oversight of this service. Case managers may assist in the provision of health promotion activities.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☒ Nurses

**Description**

Health Home team RNs will have primary responsibility for the provision of health promotion activities. Nurses will create and facilitate groups targeting health promotion (i.e. nutrition, smoking cessation, exercise) as well as meet with participants individually to monitor and encourage health promotion activities. Nurses will provide educational materials to individuals and be available as primary consultants for any questions related to health promotion activities.

☐ Medical Specialists

☒ Physicians

**Description**

Physicians will have routine contact with Health Home patients and will encourage participation in health promotion activities.

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☐ Other (specify)

### Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

#### Definition

The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. IHH/ACT Provider manual defines the care transition protocols that OTP HHs must implement. Patient information and care transition records will be shared in real time to improve the quality of care delivered and to ensure a smooth transition for all patients. The IHH team will ensure collaboration between consumers and medical professionals to reduce missed appointments and dissatisfaction with care. Specific functions include:

- Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs. For all medical and behavioral health inpatient stays, the IHH team conducts an on-site visit with client early in the hospital stay, participates in discharge planning, and leads the care transition until the client is stabilized.
- Upon hospital discharge (phone calls or home visit):
- Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
- Assist consumer to identify and obtain answers to key questions or concerns.
- Ensure the consumer understands their medications, can identify if their condition is worsening and how to respond, knows how to prevent a health problem from becoming worse, and has scheduled all follow-up appointments.
- Prepare the consumer for what to expect if another care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
- Identify linkages between long-term care and home and community-based services.

#### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The State implemented Current Care via the State Health Information Exchange (RIQH). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQH and is being purchased through the SIM initiative to increase the capacity of CMHCs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

The CMHO will be required to achieve the following preliminary standards:

1. Program has structured information systems, policies, procedures, and practices to create, document, implement, and update a treatment plan for every consumer.
2. Health Home provider has a systematic process/system to follow-up on tests, treatments, services/referrals which is integrated into the consumer's treatment plan. Guidance: Programs have a system/process to identify, track, and proactively manage the consumers' care needs using up-to-date information. In order to coordinate and manage care, the program practice has a system in place to produce and track basic information about its consumer population, including a system to proactively coordinate/manage care of a consumer population with specific disease/health care needs.
3. The program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team of providers, and which allows for population management/identification of gaps in care including preventative services.
4. Programs are committed to work with Rhode Island's health information exchange system (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance regarding information, policies, standards, and technical approaches governing health information exchange. Guidance: Provider is committed to promote, populate, use, and access data through the statewide health information exchange system. Provider is to work with RI's Health Information Exchange to ensure they receive the technical assistance in regards to any of the above requirements.
5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.
6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post-discharge follow-up care.

#### Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

#### Description

The Master's Level team leader will need to assess the consistency of the care plan(s) established in relation to the clinical treatment plan. This person will interact with other providers in addressing the patient's treatment and health needs while in another setting and work with the team to establish a transitional plan. The case manager will be responsible for the application of services in a transitional care plan. The case manager will be responsible for assuring the patient is able to follow through with transition plans and is assisted in doing so. The hospital liaison will work closely with the hospital staff, especially discharge planners, to assess the suitability of transition plans. Hospital liaisons will work with other long term facilities to plan for coordination of care during and after a residential stay.

Behavioral Health professional shall have the following qualifications:  
be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional;

or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed; at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☒ Nurses

**Description**

The registered nurse will be the primary provider/monitor of transitional care activities. Nurses have the most day-to-day interaction with other physical health care providers. Nurses are responsible for the oversight of medication delivery and administration. The RN will be the party responsible to develop the transitional care plan and accommodate any of the needs of individuals, such as transportation, ambulation, and risk of infection, etc.

- ☐ Medical Specialists
- ☒ Physicians

**Description**

The team physician will be responsible for the review of other treatment received and re-integration in the CMHO setting. Physicians will need to coordinate with other physicians to ensure continuity of care. Physicians will guide other team members in the establishment of a transitional care plan.

- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☐ Other (specify)

**Individual and Family Support (which includes authorized representatives)**

**Definition**

IHH team will provide practical help and support, advocacy, coordination, and direct assistance in helping clients to obtain medical and dental health care. Services include individualized education about the client's illness and service coordination for clients with children (e.g. services to help client fulfill parenting responsibilities, services to help client restore relationship with children, etc.). IHH peer specialists will help consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support validates clients' experiences, guides and encourages clients to take responsibility for their own recovery. In addition, peer supports will:

- Help clients establish a link to primary health care and health promotion activities,
- Assist clients in reducing high-risk behaviors and health-risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise,
- Assist clients in making behavioral changes leading to positive lifestyle improvement, and
- Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The State implemented Current Care via the State Health Information Exchange (RIQH). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in

the process of providing a care management dashboard that will send real-time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM initiative to increase the capacity of CMHCs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

**Scope of service**

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

**Description**

All members of the Health Home teams may be involved in the provision of individual and family support services. While case managers may have primary responsibility, it is reasonable to assume that all of a Health Home client's supports may have access to all team members.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☒ Nurses

**Description**

Nurses may involve family in instructions for following care plans and discussions around medication adherence.

☐ Medical Specialists

☒ Physicians

**Description**

Doctors may include family members or patient advocates in their meetings with patients.

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

**Referral to Community and Social Support Services**

**Definition**

**OVERARCHING STATEWIDE DEFINITION:** Referrals to community and social support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical, behavioral, educational, social and community issues.

**CMHC-SPECIFIC DEFINITION:** Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and improve overall health. Referral to

community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to: - Primary care providers and specialists; - Wellness programs, including smoking cessation, fitness, weight loss programs, yoga; - Specialized support groups (i.e. cancer, diabetes support groups); - Substance treatment links in addition to treatment - supporting recovery with links to support groups, recovery coaches, 12-step; - Housing; - Social integration (NAMI support groups, MHCA OASIS, Alive Program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Center; - Assistance with the identification and attainment of other benefits; - Supplemental Nutrition Assistance Program (SNAP); - Connection with the Office of Rehabilitation Service as well as internal CMHO team to assist person in developing work/education goals and then identifying programs/jobs; - Assisting person in their social integration and social skill building; - Faith based organizations; - Access to employment and educational program or training; - Referral to community and social support services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing referrals to community and social support services.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The State implemented Current Care via the State Health Information Exchange (RIQI). CurrentCare allows authorized providers to see their clients' health information using secure technology. CurrentCare lets authorized providers view clients' health information from different doctors, hospitals and laboratories, which results in far more certainty and safety, less paperwork and greater satisfaction all around. The State is also in the process of providing a care management dashboard that will send real time alerts of inpatient and ED visits to CMHCs. This dashboard was developed by RIQI and is being purchased through the SIM Initiative to increase the capacity of CMHCs (the only providers of IHH and ACT services) to be responsive to inpatient utilization by their clients.

**Scope of service**

**The service can be provided by the following provider types**

☒ Behavioral Health Professionals or Specialists

**Description**

Case managers will make the majority of referrals that are not specific to medical appointments, though would not be restricted from doing so when appropriate. Case managers are the primary link to resources of recovery support in the community. Working with the Master's Level Team Leader, case managers will be responsible for maintaining updated lists of resources with contact information. Case managers will ensure follow through on referrals and assist patients, when needed, in getting to appointments or ensuring connection.

Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☒ Nurses

**Description**

Nurses will be the primary source of referral for medical appointments, ensuring that patients are properly referred and that essential information is provided and received.

☐ Medical Specialists

☒ Physicians

**Description**

Physicians may make referrals for HH patients on a regular basis. It would be expected that in referrals to specialty care for individuals with specific complications, a physician referral would be most appropriate.

☐ Physician's Assistants

- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☐ Other (specify)



## Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

## Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Clients eligible for IHH services will meet diagnostic and functional criteria established by BHDDH. Individuals will also be assessed for eligibility using the Daily Living Activities (DLA) Functional Assessment. The DLA must be completed at admission and every 6 months after admission as well as after an IP admission or significant change in clinical presentation. The assessment tool identifies where interventions are needed for rehabilitation and recovery so clinicians can address those functional deficits on individualized treatment plans. Individuals who do not meet diagnostic criteria, but require IHH services due to significant functional impairment as measured by the DLA, may be admitted to the program through an exception process established by BHDDH in collaboration with MCOs. For all HH admissions, a BHDDH enrollment form must be completed and kept in the client's medical record. The Provider must submit a HH admission request via the HP web portal. The client's primary eligible diagnosis, the DLA score and the program (OTP, IHH or ACT) must be entered in the portal. In addition, CMHO will verify that client has signed an agreement to receive ACT/IHH services or needs this level of service and was unable/unwilling to sign. Staff at BHDDH will review and either approve or deny requests within 2 business days. A comprehensive and culturally appropriate health assessment is used. Each client will be assigned a service coordinator (case manager) who coordinates and monitors the activities of the client's individual treatment team and the greater IHH/ACT team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences.

Name

Date Created

Health Homes Patient Flow\_IHH/ACT\_6.29.18

6/29/2018 1:09 PM EDT



## Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

### Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

### Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

The state will determine baseline costs of Medicaid and Medicare beneficiaries who would have been eligible for CMHO health home services at any time during the 4th quarter of state fiscal year 2011 (April 2011 through June 30, 2011). In order to calculate costs savings and the impact of health home services, the State will perform an annual assessment of baseline costs compared with total Medicaid and Medicare costs of those same CMHO health users one year and two years following the SPA effective date. The assessment will also include the performance measures enumerated in the Quality Measures section. In addition to looking at overall cost, BHDDH will work with EOHHS to determine specific targeted areas of cost most likely to be impacted by health home implementation for a more detailed analysis. In order to perform both of these operations, the State will require timely and affordable access to Medicare data.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

The state will phase-in the use of HIT to support health home services. Initially, providers will be supported in their delivery of health home services through data profiles supplied by Medicaid Managed Care Organizations (MCOs) for the 35% of the health home-eligible SPMI population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below. To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid. The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data, including: 1) Claims Data to identify member's pattern of utilization based on previous 12-months: • #Emergency Room Visits • Last ER Visit Date • Last ER Visit Primary Diagnosis • #Urgent Care Visits; 2) Claims data to identify member's primary care home: • #PCP Sites • PCP visits to current PCP Site • Last PCP visit date to current PCP Site • Current PCP Provider NPI • Last PCP Visit to current PCP Site Provider NPI • #PCP visits to other Providers • Last PCP visit date to other Providers • Last PCP visit to other PCP Site Provider NPI; 3) Health utilization profile developed by MCOs as part of the CMHO certification process. The state will query providers about the use of HIT in the delivery of care coordination services. The state may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care and quality of care among clients.

## Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | RI2018MS00060 | RI-18-0006 | Migrated\_HH.CONVERTED Rhode Island-2 Health Home Services

## Package Header

Package ID	RI2018MS00060	SPA ID	RI-18-0006
Submission Type	Official	Initial Submission Date	6/29/2018
Approval Date	9/27/2018	Effective Date	6/1/2018
Superseded SPA ID	RI-16-0002-X		
	System-Derived		

## Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Records / Submission Packages

# RI - Submission Package - RI2016MH00040 - (RI-16-006)

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## Submission - Summary

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

### Package Header

Package ID	RI2016MH00040	SPA ID	RI-16-006
Submission Type	Official - Review 1	Initial Submission Date	9/29/2016
Approval Date	12/9/2016	Effective Date	N/A
Superseded SPA ID	N/A		

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### State Information

State/Territory Name  
Rhode IslandMedicaid Agency Name  
Executive Office of Health and Human Services

### Submission Component

☒ State Plan Amendment☐ Medicaid  
☐ CHIP

### Submission Type

☒ Official Submission Package  
☐ Draft Submission Package

Allow this official package to be viewable by other states?

☐ Yes  
☒ No

### Key Contacts

Name	Title	Phone Number	Email Address
McDonald, Darren	Deputy Medicaid Director	(401)462-1965	darren.mcdonald@ohhs.ri.gov
Lawrence, Melody	Health Services Manager	(401)462-6348	melody.lawrence@ohhs.ri.gov

## SPA ID and Effective Date

+/-

SPA ID RI-16-006

Reviewable Unit	Proposed Effective Date
Health Homes Intro	7/1/2016
Health Homes Population and Enrollment Criteria	7/1/2016
Health Homes Geographic Limitations	7/1/2016
Health Homes Services	7/1/2016
Health Homes Providers	7/1/2016
Health Homes Service Delivery Systems	7/1/2016
Health Homes Payment Methodologies	7/1/2016
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2016

## Executive Summary

+/-

**Summary  
Description  
Including Goals  
and Objectives**

The Opioid Treatment Programs (OTP) Health Homes provide resources to opioid dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment through Managed Care as well as Fee-for Service. Data shows most patients are between the ages of 31-64, 86% smoke and all either have or are at risk for: COPD, Cardiac disease, Obesity, Diabetes, Hepatitis C, Viral illnesses.

OTPs provide the opportunity for daily contact with Medical and Clinical professionals who have on-going therapeutic relationships with patients. This enables providers to use existing and enhanced resources to improve the health of patients and decrease inadequate/ineffective medical care. Provision of this service positively impacts the health and welfare of patients, and reduce overall healthcare costs by: Focusing on relationships with primary and specialty care vs. emergency care; Wellness promotion; Routine health monitoring; Pain management; Care management to develop recovery supports that promote self-care.

Each patient is assigned to a team which may be specialized to their specific healthcare needs. Patients have an assigned nurse and case manager to: Monitor healthcare needs; Assist with referral, scheduling, and transportation to medical and other appointments; Develop a health plan; Provide health promotion and wellness activities; Facilitate transitions between levels of care; Support recovery needs; Identify and provide resources that support wellness and recovery.

This Health Home model provides the mechanism to support stronger, formalized relationships between OTPs and community healthcare providers. By bringing OTP HH into Managed Care, providers will receive additional support for reporting and additional assistance in identifying eligible members in need of OTP HH services. OTP HH offers a comprehensive, holistic approach including diagnosis, treatment, support, education, and coordination, improving quality of life, stability, management of chronic conditions, and decreased healthcare costs.

Rhode Island is seeking to augment services offered through the OTP Health Home, through the creation of Centers of Excellence (COE). The COE are intended to expand and enhance the statewide capacity for Medication Assisted Treatment (MAT), increasing accessibility, not only in COEs, but through community providers, improving the quality of care and patient satisfaction. COEs will provide assessments and treatment for opioid dependence, will offer expedited access to care, and serve as a resource to community based providers. The goal of the COE is to provide intensive services to individuals needing to stabilize on medication and begin the recovery process. Once stable, patients will be referred to community-based providers, but still have the opportunity to maintain connections to clinical or recovery support services offered by the COE. Once referred to the community, patients who need more intensive services, perhaps due to relapse or crisis, will have the opportunity for immediate readmission to the COE. The COEs will also have the ability to provide on-site training for physicians and other professionals. Center of Excellence Certification Standards have been developed; in order to serve as a COE, the OTP Health Home will need to apply and will be assessed according to the COE Certification Standards. Certified COEs will be authorized to provide a set of enhanced treatment services to Medicaid beneficiaries who require MAT using buprenorphine or injectable naltrexone for opioid use disorders.

The COE will achieve the following goals: 1) increase the number of admissions into MAT, 2) increase in the number of clients receiving integrated care and treatment, 3) decrease use of illicit opioid, 4) decrease use of prescription opioids in a non-prescribed manner (i.e.: misuse or abuse of prescription opioids).

## Dependency Description

+/-

**Description of any  
dependencies  
between this  
submission  
package and any  
other submission  
package  
undergoing review**

COE staffing model includes the use of peer support specialists. CMS is currently reviewing RI's Category 2 waiver request for Peer Support Specialists, change number 15-07-CII.

**Disaster-Related Submission**

+/-

This submission is related to a disaster

- ☐ Yes  
☒ No

**Federal Budget Impact and Statute/Regulation Citation**

+/-

**Federal Budget Impact**

Federal Fiscal Year		Amount
First	2016	\$248,125.00
Second	2017	\$992,500.00

**Federal Statute / Regulation Citation**

Section 1945 SSA

**Governor's Office Review**

+/-

- ☐ No comment  
☐ Comments received  
☐ No response within 45 days  
☒ Other

**Describe** This amendment has not been reviewed specifically with the Governor's Office. Under the Rhode Island Medicaid State Plan, the Governor has elected not to review the details of state plan materials. However, in accordance with Rhode Island law and practice, the Governor is kept apprised of major changes in the state plan.

**Authorized Submitter**

+/-

The following information will be provided by the system once the package is submitted to CMS.

Name of  
Authorized  
Submitter

Title None

Phone number 4015986071

Email address melody.lawrence@ohhs.ri.gov

Authorized  
Submitter's  
Signature

☒ I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

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MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

Package ID RI2016MH0004O

SPA ID RI-16-006

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/9/2016

Effective Date N/A

Superseded SPA ID N/A

[View Implementation Guide](#)**Submission - Medicaid State Plan**

The submission includes the following

☒ Benefits☒ Health Homes Program☒ Create new Health Homes program☐ Amend existing Health Homes program☐ Terminate existing Health Homes program☒ Copy from existing Health Homes program☐ Create new program from blank form

Name of Health Homes Program RI Opioid Treatment Program Health Home Services

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**RI - Submission Package - RI2016MH0004O - (RI-16-006)**[Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Submission - Public Comment**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

Package ID RI2016MH0004O

SPA ID RI-16-006

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/9/2016

Effective Date N/A

Superseded SPA ID N/A

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Name of Health Homes Program RI Opioid Treatment Program Health Home Services

**Indicate whether public comment was solicited with respect to this submission.**

- ☐ Public notice was not required and comment was not solicited
- ☐ Public notice was not required, but comment was solicited
- ☒ Public notice was required and comment was solicited

**Indicate how the public notice was issued and public comment was solicited**

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☒ Email to Electronic Mailing List or Similar Mechanism

Date of Email or other electronic notification Jun 29, 2016

Description of mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used

Public notice is electronically emailed to EOHHS' list of interested parties. Such mailing list includes, but is not limited to providers, advocates, and other state agencies.

☒ Website Notice**Select the type of website**☒ Website of the State Medicaid Agency or Responsible Agency

Date of Posting Jun 29, 2016



Website URL <http://www.eohhs.ri.gov/ReferenceCenter/StatePlanAmendmentsand1115WaiverChanges.aspx>☐ Website for State Regulations☐ Other

☒ Public Hearing or Meeting

Date of meeting	Time of meeting	Location of meeting
8/19/2016	10:00 AM	Arnold Conference Center, Eleanor Slater Hospital John O. Pastore Complex, 111 Howard Avenue Cranston, RI 02920

☐ Other method

## Upload copies of public notices and other documents used

Name	Date Created	Type
Interested parties OTP HH	9/17/2016 9:18 PM EDT	
Notice to Public	9/17/2016 9:19 PM EDT	

## Upload with this application a written summary of public comments received (optional)

Name	Date Created	Type
No items available		

## Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

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MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

<b>Package ID</b>	RI2016MH0004O	<b>SPA ID</b>	RI-16-006
<b>Submission Type</b>	Official - Review 1	<b>Initial Submission Date</b>	9/29/2016
<b>Approval Date</b>	12/9/2016	<b>Effective Date</b>	N/A
<b>Superseded SPA ID</b>	N/A		

[View Implementation Guide](#)**Name of Health Homes Program** RI Opioid Treatment Program Health Home Services

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

☒ Yes  
☐ No

This state plan is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

☒ Yes  
☐ No

☒ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any tribal consultation conducted with respect to this submission

Tribal consultation was conducted in the following manner

☒ Indian Health Programs

Name of Program	Date of consultation	Method/Location of consultation
Narragansett Indian Health Center	6/29/2016	Email and letter via US Postal Service

☐ Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation

☐ Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	Type
------	--------------	------

TN OTP HH 6.29.16

9/17/2016 9:25 PM EDT

**Indicate the key issues raised (optional)**

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

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Records / Submission Packages

**RI - Submission Package - RI2016MH0004O - (RI-16-006)** [Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Submission - SAMHSA Consultation**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

Package ID RI2016MH0004O

SPA ID RI-16-006

Submission Type Official - Review 1

Initial Submission Date 9/29/2016


Approval Date 12/9/2016

Effective Date N/A

Superseded SPA ID N/A

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Name of Health Homes Program RI Opioid Treatment Program Health Home Services

 The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation

10/18/2012

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Records / Submission Packages

**RI - Submission Package - RI2016MH00040 - (RI-16-006)**[Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Health Homes Intro**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

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**Package Header**

Package ID RI2016MH00040

SPA ID RI-16-006

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/9/2016

Effective Date 7/1/2016

Superseded SPA ID N/A

[View Implementation Guide](#)[View All Responses](#)**Program Authority**

+/-

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program RI Opioid Treatment Program Health Home Services

**Executive Summary**

+/-

**Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used**

The Opioid Treatment Programs (OTP) Health Home proposal seeks to provide patients with resources to navigate an often fragmented service delivery system. The target population for this proposal is opioid dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment. Data shows most patients are between the ages of 31-64, 86% smoke and all either have or are at risk for: COPD, Cardiac disease, Obesity, Diabetes, Hepatitis C, Viral illnesses.

OTPs provide the opportunity for daily contact with Medical and Clinical professionals who have on-going therapeutic relationships with patients. This will enable providers to use existing and enhanced resources to improve the health of patients and decrease inadequate/ineffective medical care. Provision of this service will positively impact the health and welfare of patients, and reduce overall healthcare costs by: Focusing on relationships with primary and specialty care vs. emergency care; Wellness promotion; Routine health monitoring; Pain management; Care management to develop recovery supports that promote self-care.

Each patient would be assigned to a team which may be specialized to their specific healthcare needs. Patients would have an assigned nurse and case manager to: Monitor healthcare needs; Assist with referral, scheduling, and transportation to medical and other appointments; Develop a health plan; Provide health promotion and wellness activities; Facilitate transitions between levels of care; Support recovery needs; Identify and provide resources that support wellness and recovery.

This Health Home model will provide the mechanism to support stronger, formalized relationships between OTPs and community healthcare providers. This offers a comprehensive, holistic approach including diagnosis, treatment, support, education, and coordination, improving quality of life, stability, management of chronic conditions, and decreased healthcare costs.

**General Assurances**

+/-

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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Records / Submission Packages

**RI - Submission Package - RI2016MH0004O - (RI-16-006)**[Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Health Homes Population and Enrollment Criteria**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

Package ID RI2016MH0004O

SPA ID RI-16-006

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/9/2016

Effective Date 7/1/2016

Superseded SPA ID N/A

[View Implementation Guide](#)[View All Responses](#)**Categories of Individuals and Populations Provided Health Homes Services**

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The state will make Health Homes services available to the following categories of Medicaid participants

☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups☒ Medically Needy Eligibility GroupsMandatory Medically Needy☒ Medically Needy Pregnant Women☒ Medically Needy Children under Age 18Optional Medically Needy (select the groups included in the population)**Families and Adults**☒ Medically Needy Children Age 18 through 20☒ Medically Needy Parents and Other Caretaker Relatives**Aged, Blind and Disabled**☒ Medically Needy Aged, Blind or Disabled☒ Medically Needy Blind or Disabled Individuals Eligible in 1973**Population Criteria**

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The state elects to offer Health Homes services to individuals with

☐ Two or more chronic conditions☒ One chronic condition and the risk of developing another**Specify the conditions included**☐ Mental Health Condition☒ Substance Use Disorder



- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI over 25
- ☐ Other (specify)

#### Specify the criteria for at risk of developing another chronic condition

Patients will be assessed for the risk of developing another chronic condition using a uniform checklist at each provider site. This form will address high risk behaviors and other risk factors for chronic conditions such as, but not limited to: smoking; obesity; poor nutrition; childhood trauma; risky sex practices; intravenous drug use; history of or current abuse of substances other than opioids; family health history. These forms will be completed at assessment for new patients, at admission to Health Home programs for current patients and annually at each physical appointment.

- ☐ One serious and persistent mental health condition

## Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- ☐ Opt-In to Health Homes provider
- ☒ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

#### Describe the process used


Health Home participants receiving MAT for opioid dependence and COE participants will be identified via provider or community partner referrals, such as the judicial system or emergency departments, and outreach to prior patients who were discharged due to no contact. Physicians, other providers, managed care organizations, treatment centers, and criminal justice system professionals will be made aware of the integrated MAT system and referral process through a variety of means, including websites and other notices, Grand Rounds, community meetings, and provider agreements.

All eligible patients currently enrolled in Opioid Treatment Programs will be provided a letter explaining Health Home/COE Services and automatic enrollment with information on how to opt-out. Patients will be given the opportunity to meet with Health Home/COE team representatives to discuss their options. All new patients will be given information on Health Homes Services upon admission and the opportunity to opt-out at that time. Opportunities for opting-out will be provided initially and then annually. Providers are required to have clients sign an enrollment form. The provider keeps the enrollment form in the client's medical record. Every 6 months, providers attest to the fact that an enrollment form was signed for all clients enrolled in the program.

COE participants will not be automatically disenrolled from COE unless discharged.

Patients who initially accept OTP HH services, but who do not consistently participate in any given 90 day period, may be disenrolled by the provider after demonstrated engagement and outreach efforts. Re-enrollment options are always available for initial or subsequent patients who decline health homes. Beneficiaries will be able to agree or decline to receive specific Health Home services during their participation in developing the individualized Plan of Care. Declining Health Home services will have no effect on their regular Medicaid benefits. The Health Home will notify other treatment providers about the goals and types of available Health Home services and involve them in Health Home activities for shared patients. Individuals receiving services in a hospital ED or as an inpatient who may be eligible for Health Home services will be notified about their availability and referred based on patient choice.

- ☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Name	Date Created	Type
Health Home Opt-out Form - Final	9/17/2016 9:46 PM EDT	

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Records / Submission Packages

**RI - Submission Package - RI2016MH0004O - (RI-16-006)** [Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Health Homes Geographic Limitations**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

Package ID RI2016MH0004O

SPA ID RI-16-006

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Initial Submission Date 9/29/2016

Approval Date 12/9/2016

Effective Date 7/1/2016

Superseded SPA ID N/A

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- ☒ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☐ Health Homes services will be provided in a geographic phased-in approach

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Records / Submission Packages

**RI - Submission Package - RI2016MH00040 - (RI-16-006)**[Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Health Homes Services**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

Package ID RI2016MH00040

SPA ID RI-16-006

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Initial Submission 9/29/2016  
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Approval Date 12/9/2016

Effective Date 7/1/2016

Superseded SPA N/A  
ID[View Implementation Guide](#)[View All Responses](#)**Service Definitions**

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Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

**Comprehensive Care Management****Definition**

Comprehensive care management is provided for patients, families and supports, to develop and implement a whole-person care plan and monitor the patient's success in achieving goals.

A bio-psychosocial assessment of physical, behavioral, psychological status and social functioning, along with a physical exam, is conducted for each person admitted to an OTP. Per BHDDH licensing regulations, the bio-psychosocial assessment must be completed at intake, reviewed annually, and updated in entirety every five (5) years. This determines the appropriate level of care; need for specialized medical/psychological evaluations; need for family participation or other supports; and the staff and/or program to provide the care.

Based on the assessment a goal-oriented, person centered care plan is developed and implemented by a multi-disciplinary team, which includes the patient served.

The healthcare liaison, whose primary function is to establish and maintain primary/specialty care provider relationships, provides a process for outreach, planning, and communication. These relationships promote multidisciplinary treatment recommendations and planning by fostering consistent access and communication.

Communication of patient preferences is incorporated throughout the Health Home process. Consumer driven care plans focus on the desired goals of the patient. Communication with providers will reference patient preference and choice. Case management can teach patients self advocacy to communicate preferences.

Most of the team composition is experienced in the provision of services to OTP patients. Programs will focus on role expansion and training to incorporate the holistic healthcare perspective. Case managers will be recruited and trained in a Health Home model of care.

Recovering individuals are central to a recovery oriented system of care. Rhode Island has two established recovery support centers able train medication assisted advocates and has a cadre of Certified Recovery Coaches accessible to OTP patients. Upon patient request, Recovery Coaches will participate in planning and implementation of Health Home services.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

All six of the current OTP providers have electronic health records. Three of these providers use software that is certified for meaningful use - representing more than half of the OTP population. Providers have adopted a standardized assessment tool that can be updated to reflect outcomes. OTP HHs received training on utilizing an ASAM PPC assessment tool that provides standardized outcome measures.

OTPs are required to submit patient specific data to the RI Behavioral Health Online Data (RIBHOLD) system at admission, discharge and relevant changes in condition. OTPs will receive training from BHDDH on extraction and meaningful use of the data in RIBHOLD. RIBHOLD data is used to provide outcomes to SAMHSA to reflect changes in abstinence rates, housing, employment, social connections, criminal justice involvement, and retention in treatment (NOMs).

The information collected extends beyond these basic measures to include relevant comorbid conditions. Health Homes would provide OTPs with additional training and incentive to use updated data submissions to identify and document the effectiveness of the Health Home model on multiple outcomes, including

health condition.

Care plans established at the OTPs can be shared with multiple providers using the State's HIE – CurrentCare with the client's consent. The HIT coordinator position will assist programs in becoming data sharing partners and/or participants in the CurrentCare Direct Messaging feature. This participation will facilitate the sharing of care plans and reduce duplication of effort. Current Care representatives have been and will continue to be participants in the OTP Health Home planning process.

#### Scope of service

#### The service can be provided by the following provider types

##### ☒ Behavioral Health Professionals or Specialists

##### Description

Qualified Behavioral Health Specialists will conduct initial bio-psychosocial assessments and work with patients and other team members to develop care plans. Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practitioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

Case managers will be responsible for ensuring adherence to the plan, engaging family members and other supports, and monitoring outcomes. Case managers will assist patients in accessing other specialized care, encouraging patients to keep appointments and follow through with care recommendations. Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

##### ☐ Nurse Practitioner

##### ☐ Nurse Care Coordinators

##### ☒ Nurses

##### Description

Nurses will assist physicians in the admission and annual physicals. They will assist in the development of the care plan. Nurses will regularly coordinate with other healthcare providers and establish routine communications. Nurses will continue to assess patients throughout treatment and monitor progress in achieving health care plan goals.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

##### ☐ Medical Specialists

##### ☒ Physicians

##### Description

Physicians review the bio-psychosocial assessments and conduct initial and annual physicals of all OTP patients. Physicians are central to the creation of the care plan and lead teams to identify need for specialized care. Physicians monitor medication stabilization and are available to consult with all other providers.

##### ☐ Physician's Assistants

##### ☒ Pharmacists

##### Description

Pharmacists are available for consultation to the Health Home team to review patient medications and make recommendations to the care plan based on this assessment.

##### ☐ Social Workers

##### ☐ Doctors of Chiropractic

##### ☐ Licensed Complementary and alternative Medicine Practitioners

##### ☐ Dietitians

- ☐ Nutritionists
- ☐ Other (specify)

## Care Coordination

### Definition

Care coordination involves implementing an individualized care plan to attain goals and improve chronic conditions. Care managers are responsible for conducting these activities across all settings. This service provides case management necessary to access medical, social, vocational, educational, and other services, including, but not limited to: Assistance in accessing health care and follow-up care; Assessing housing needs - providing assistance to access and maintain safe/affordable housing; Conducting outreach to family members and others to support connections to services, and expand social networks; Assisting in locating community services in medical, social, legal and behavioral healthcare areas and ensuring that all services are coordinated; Coordinating with other providers to monitor health status, medical conditions, medications/side effects; Coordinating with other entities such as the member's Managed Care Organization, the criminal justice system, Child and Family Court and DCYF.

Currently OTPs have established relationships with some primary care and medical specialty providers in their regions. Regular contact occurs with hospitals regarding medication verification and continuity of care. OTPs also have relationships with private psychiatrists and community mental health organizations. These linkages can be strengthened and formalized as OTPs become Health Home providers.

Memorandums of understanding are used consistently by OTPs as standard practice when working with community providers. Formal agreements are less prevalent with recovery support services. Health Homes can provide the impetus to expand the recovery support network.

As 42 CFR Part II programs, OTPs are aware of the need for compliant consent forms. The state has established a standardized process to share Part II information with the statewide Health Information Exchange (CurrentCare). Patients are fully apprised of consent choice and confidentiality regulations as they pertain to substance abuse treatment.

### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

OTPs will be able to link electronic health records to the State Health Information Exchange - CurrentCare. Behavioral Healthcare Organizations (including OTPs) are required by regulation to offer enrollment in the CurrentCare system. Regulations provide access to an approved authorization to release information from that provides compliant data exchange with 42 CFR Part II protected information. OTPs understand and meet the requirements of HIPAA relevant to information sharing. Three of these OTPs - representing more than half of the OTP patients in the state, use certified EHR software. Currently the State receives regular data from the Department of Corrections on OTP patients that become incarcerated in an effort to provide continuity of care. This information is shared with the identified provider. MCOs have developed a process to notify CMHO Health Homes of any hospitalization within 24 hours in an effort to coordinate care. This process will be established for OTP Health Homes as well. MCOs have provided CMHOs with routine utilization reports and will do the same with OTPs so they are able to see where patients are - and are not - accessing care.

### Scope of service

### The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

#### Description

The position with primary responsibility for this service will be case managers. Case managers will seek input from other team members, but will be the primary contact for care plan implementation. Case managers will assist patients in accessing other services by appointment reminding, attending appointments, identifying need and associated resources. Case managers will most often be the team member with the most patient contact and outreach to patients and their supports to maintain engagement in services. Case managers will most frequently interact with providers of other services and note compliance with care recommendations. Case managers will report back to other team members on care plan implementation - success and challenges and seek input from others to enhance outcome and goal attainment.

Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners

- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Peer Recovery Coaches	Peer Recovery Coaches will be available to participants to support clients in accessing community-based resources, recovery, health and wellness support, and employment plans. A prospective Peer Recovery Specialist must meet the following criteria: a. Credentialed, or be in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at <a href="http://www.ricertboard.org/">http://www.ricertboard.org/</a> . RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC). b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS. c. Individuals who have undergone periods of homelessness may also apply for this credential.

## Health Promotion

### Definition

Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Health promotion services may be provided by any member of the OTP Health Home team. Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with:

- o Promoting individual's health and ensuring that all personal health goals are included in person centered care plans;
- o Promotion of mental health treatment, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity;
- o Providing health education to individuals and family members (where appropriate) about chronic conditions;
- o Providing prevention education to individuals and family members (where appropriate) about health screening and immunizations;
- o Providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and
- o Promoting self-direction and skill development in the area of independent administering of medication.
- o Linking the member to disease management and health education programs offered by his/her managed care organization.

### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Information will be collected on a periodic basis on individual participation in both external and internal health promotion activities. For those activities included in the EHR, this information can be shared with other providers using the CurrentCare HIE. Individuals accessing health promotion activities through the Department of Health's Chronic Disease Self-Management Program will also be tracked by the Department of Health for follow-through, participation and completion. OTP staff have been encouraged to become providers for the DOH programs and train in the Stanford Model along with offering RNs and pharmacists the opportunity to become certified diabetes outpatient coordinators and certified cardiac outpatient coordinators.

### Scope of service

### The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

#### Description

Master's level team leaders will be responsible for the oversight of this service. Care managers may assist in the provision of health promotion activities. Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☒ Nurses

#### Description

Health Home team RNs will have primary responsibility for the provision of health promotion activities. Nurses will create and facilitate groups targeting health promotion (i.e. nutrition, smoking cessation, exercise) as well as meet with participants individually to monitor and encourage health promotion activities. Nurses will provide educational materials to individuals and be available as primary consultants for any questions related to health promotion activities.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

- ☐ Medical Specialists
- ☒ Physicians

#### Description

Physicians will have routine contact with Health Home patients and will encourage participation in health promotion activities.

- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Peer Recovery Coaches	<p>Peer Recovery Coaches will provide the following: serve as a role model for the integration of recovery, health and wellness, and employment; provide education to individuals regarding services and benefits available to assist in transitioning into and staying in the workforce; navigating state and local systems (including addiction and mental health treatment systems); mentoring individuals as they develop strong foundations in recovery and wellness; and promoting empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences. A prospective Peer Recovery Specialist must meet the following criteria:</p> <p>a. Credentialed, or in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at <a href="http://www.ricertboard.org/">http://www.ricertboard.org/</a>. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&amp;RC).</p> <p>b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS.</p> <p>c. Individuals who have undergone periods of homelessness may also apply for this credential.</p>

### Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

#### Definition

Comprehensive transitional care services focus on the transition of patients from any long-term care facility or other out-of-home setting into the community. Health Home team members work closely with the patient to transition smoothly back to the community and share information with discharging organizations to prevent gaps in care that could result in re-admission.

To facilitate timely and effective transitions, all OTPs will maintain collaborative relationships with emergency departments, local hospitals, long-term care and residential facilities and other applicable settings. OTP HH Program manual defines the care transition protocols that OTP HHs must implement. OTPs will utilize healthcare liaisons to assist in discharge planning - existing OTP patients and new referrals - from inpatient settings to OTPs. Care coordination will also assist in transitioning incarcerated individuals.

Healthcare liaisons, care coordinators and other team members will provide transitional care services. The team will collaborate with physicians, nurses, social workers, discharge planners and pharmacists within the hospital or residential setting to ensure a care plan has been developed and work with family members (where appropriate) and community providers to ensure that the plan is communicated, adhered to and modified as indicated.

When an OTP patient is admitted to a hospital, there is dialogue with medical staff for medication verification. Education is provided to hospitals regarding OTP Health Home services and this dialogue can be expanded beyond dosing information to continuity of care and discharge planning.

Managed Care Organizations and Medicaid have created mechanisms for periodic utilization reports provided to OTP HHs. In fact, MCOs have developed next day notification procedures to Health Homes on all hospital admissions.

#### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health information technology is crucial in establishing effective, comprehensive transitional care. Currently, all OTPs have electronic medical records, though may not be able to share health record information easily. Providers are encouraged to participate in Direct Messaging available through the State's Health Information Exchange - CurrentCare. Direct Messaging allows providers to share information securely and efficiently.

Data that is submitted through RIBHOLD is currently accessed online by the providers to prevent dual enrollment. If a client is currently active in one program, another will not be able to admit until that client is "cleared" for admission by being discharged. OTP providers are very accustomed to using this form of HIT to coordinate care amongst themselves. Easy access to enrollment data allows providers to request prior treatment information that will assist them in development of a comprehensive treatment approach.

BHDDH also receives daily census data from the Department of Corrections in order to alert providers that an active OTP patient has been incarcerated and to provide continuity of care during at least the initial period of incarceration.

Through a collaborative process with MCOs, OTPs will be provided with quarterly utilization reports for their clients, enabling them to address need for coordination and transition. OTPs will also receive next day notification by MCOs on any Health Home patient that is hospitalized. These standard reports will be submitted to OTPs on a regular basis and assist in the effective provision of transitional care services.

OTPs have relationships with providers of long term care services including nursing facilities and substance abuse residential treatment. These providers may also participate in Direct Messaging enabling OTPs to provide and receive information enhancing their ability to meet client needs in transitioning.

#### Scope of service

#### The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

#### Description

The Master's Level team leader will need to assess the consistency of the care plan(s) established in relation to the clinical treatment plan. This person will interact with other providers in addressing the patient's treatment and health needs while in another setting and work with the team to establish a transitional plan.

The case manager will be responsible for the application of services in a transitional care plan. The care manager will be responsible for assuring the patient is able to follow through with transition plans and is assisted in doing so.

Case managers in OTPs and COEs must meet the state's behavioral



healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

The hospital liaison will work closely with the hospital staff, especially discharge planners, to assess the suitability of transition plans. Hospital liaisons will work with other long term facilities to plan for coordination of care during and after a residential stay.

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☒ Nurses

#### Description

The registered nurse will likely be the primary provider/monitor of transitional care activities. Nurses have the most day-to-day interaction with other physical health care providers. Nurses are responsible for the oversight of medication delivery and administration. The RN will be the party responsible to develop the transitional care plan and accommodate any of the needs of individuals, such as transportation, ambulation, and risk of infection, etc.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

- ☐ Medical Specialists
- ☒ Physicians

#### Description

The team physician will be responsible for the review of other treatment received and re-integration in the outpatient setting. Physicians will need to coordinate with other physicians to ensure continuity of care. Physicians will guide other team members in the establishment of a transitional care plan.

- ☐ Physician's Assistants
- ☒ Pharmacists

#### Description

Patients transitioning from long term programs or hospitalizations may have the need for a medication review by the pharmacist to ensure that medications prescribed during or post these stays will not adversely interact with methadone.

- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

### Individual and Family Support (which includes authorized representatives)

#### Definition

Patient Support Services provide quality care that allows clients to maintain independence and improve the quality of their lives. This support may involve families, communities, professionals and any other entity identified by the patient as integral to their recovery process. Individual support services, including family where appropriate, are provided by the care coordinator and other members of the health team to reduce barriers to individuals' care coordination, increase skills, engagement and improve health outcomes. These services may include, but are not limited to:

- o Providing assistance in accessing needed self-help and peer support services;
- o Advocacy for individuals and families;
- o Assisting individuals to identify and develop social support networks;
- o Assistance with medication and treatment management and adherence;
- o Identifying resources that will help individuals and their families reduce barriers to promote the highest level of health and success;
- o Connection to peer advocacy groups, wellness centers, Rhode Island Coalition for Addiction and Recovery Efforts (RICares), Faces and Voices of Recovery (FaVoR) and psycho-educational programs; and
- o Individual and family support (where appropriate) services that may be provided by any member of the OTP Health Home team.

OTP Health Homes provide support, education and resources to any family member as defined by the patient.

#### Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

With appropriate consents to release information, family and other supports of Health Home participants may have access to relevant information contained in the electronic health record. Such information may be useful to supports for developing appropriate recovery plans and engaging patients in open discussions around needs and follow through. Families may also provide helpful collateral information that may guide the assessment and care planning for the individual. Families may have need to access information through HIT in the event of emergency or potentially for legal issues. Family members can be made aware of provider's participation in Direct Messaging and in the event of an emergency can let responders know that there is information to be accessed in that manner.

**Scope of service****The service can be provided by the following provider types**

☒ Behavioral Health Professionals or Specialists

**Description**

All members of the Health Home teams may be involved in the provision of individual and family support services. While care managers may have primary responsibility, it is reasonable to assume that all of a Health Home client's supports may have access to all team members. Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☒ Nurses

**Description**

Nurses may involve family in instructions for following care plans and discussions around medication adherence.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

☐ Medical Specialists

☒ Physicians

**Description**

Doctors may include family members or patient advocates in their meetings with patients.

☐ Physician's Assistants

☒ Pharmacists

**Description**

Pharmacists may provide information to family and other supports on potential medication interactions and signs and symptoms of medication overdose.

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☒ Other (specify)

Provider Type	Description
Peer Recovery Coaches	<p>Peer Recovery Coaches will promote empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences and provide education to individuals regarding services and benefits available to assist in transitioning into and staying in the workforce. Peer Recovery Coaches will also assist in navigating state and local systems (including addiction and mental health treatment systems). A prospective Peer Recovery Specialist must meet the following criteria:</p> <p>a. Credentialed, or in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at <a href="http://www.ricertboard.org/">http://www.ricertboard.org/</a>. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&amp;RC).</p> <p>b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS.</p> <p>c. Individuals who have undergone periods of homelessness may also apply for this credential.</p>

**Referral to Community and Social Support Services****Definition**

Referral to community and social support services, including programs offered by the member's managed care organization, provides patients with a wide array of support services to help overcome barriers, increase self-management skills and achieve overall health. Appropriate referrals are driven by the assessment process and are noted on the patient's care plan in consultation with and agreement from the patient. The State assures appropriate referrals are made by monitoring the assessment, planning and care provided by OTPs.

Referral to community and social support involves facilitating access to assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. Such referrals are made through telephone or in person consultation and may include electronic transmission of requested data. Follow through on referrals will be the role of the healthcare liaison or the case manager, depending upon the type of referral. The types of community and social support services to which individuals will be referred may include, but are not limited to:

- Primary care providers and specialists;
- Wellness programs, including smoking cessation, fitness, weight loss programs or yoga;
- Specialized support groups (i.e. cancer or diabetes support groups);
- Recovery support services such as support groups, recovery coaches, 12 step groups;
- Housing, including recovery housing;
- Social integration opportunities including Recovery Centers;
- Benefit attainment assistance;
- State Nutrition Assistance Program (SNAP);
- Office of Rehabilitation Services;
- Social integration and social skill building programs;
- Faith based organizations;
- Community Mental Health Organizations;
- Higher levels of care for addiction treatment, including IOP, PHP, residential or detox that can be accessed with assistance from the member's managed care organization 24 hours per day, seven days per week.;
- Appropriate cultural support centers;
- Social Case managers, outreach workers, disease management programs and other resources offered by the member's managed care organization.

Referral to community and social support services may be provided by any member of the OTP health home team

#### **Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

Referrals to community and social support services can be made through Direct Messaging with any participating practices. It is important to note that for many of these programs, clinical detail in health records may not be needed or appropriate. OTPs making referrals to the Rhode Island Department of Health's Chronic Condition Self-Management Programs can use the established referral process. Releases are signed and a referral form is completed and then emailed to the DOH. DOH tracks the referrals and assists the patient in making and keeping appointments. Peers follow up on all referrals at least three times to insure that the patient is connecting to the service. These services include but are not limited to: arthritis exercise programs; arthritis walking with ease programs; certified diabetes and certified cardiovascular disease outpatient educators; Living Well Rhode Island; Diabetes Self-Management; Health Smart Behaviors; Draw a Breath Asthma Program; Livestrong at the YMCA; Chronic Pain self-management workshops; QuitWorks RI; YMCA's Healthy Lifestyles Behavior Change Program.

#### **Scope of service**

#### **The service can be provided by the following provider types**

##### ☒ Behavioral Health Professionals or Specialists

##### **Description**

Case managers will most likely make the bulk of referrals that are not specific to medical appointments, though would not be restricted from doing so when appropriate. Case managers are the primary link to resources of recovery support in the community. Working with the Master's Level Team Leader, case managers will be responsible for maintaining updated lists of resources with contact information. Case managers will ensure follow through on referrals and assist patients, when needed, in getting to appointments or ensuring connection.

Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

##### ☐ Nurse Practitioner

##### ☐ Nurse Care Coordinators

##### ☒ Nurses

##### **Description**

Nurses will likely be the primary source of referral for medical appointments, ensuring that patients are properly referred and that essential information is provided and received.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

##### ☐ Medical Specialists

##### ☒ Physicians

##### **Description**

Physicians may make referrals for HH patients on a regular basis. It would be expected that in referrals to specialty care for individuals with specific complications, a physician referral would be most appropriate. For the Certified Diabetes Outpatient Educator and the Certified Cardiovascular Disease Outpatient Educator Programs, the referral must come from a physician.

##### ☐ Physician's Assistants

##### ☐ Pharmacists

##### ☐ Social Workers

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)


Provider Type	Description
Peer Recovery Coaches	<p>Peer Recovery Coaches will provide education to individuals regarding services and benefits available to assist in transitioning into and staying in the workforce and will support individuals in accessing community based resources, recovery, health and wellness support, and employment services. A prospective Peer Recovery Specialist must meet the following criteria:</p> <p>a. Credentialed, or in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at <a href="http://www.ricertboard.org/">http://www.ricertboard.org/</a>. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC and RC).</p> <p>b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS.</p> <p>c. Individuals who have undergone periods of homelessness may also apply for this credential.</p>

## Health Homes Patient Flow

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Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

The attached RI flow chart depicts the Health Home process for "Alice" the opioid dependent HH client described in our previously submitted narrative. This chart identifies the process for individuals who may present in local hospital emergency departments. Through the HH process, it is expected that OTPs will work to increase their coordination of care with local hospitals and educate them on Health Home services. For an opioid dependent patient who presents in an ED, an assessment will be made as to whether that patient is currently enrolled in an OTP. If yes, they will be educated as to benefit of HH services, if no, outreach will be made to OTP hospital liaison who will offer OTP/HH services and coordinate appointment for assessment/intake. Assuming client is appropriate for treatment and decides to enroll in Health Homes, they would then be assigned to a Health Home team that may be focused on their primary chronic condition and meet with members of that team to create a recovery care plan. The patient would have access to the team nurse for any concerns, care needs and routine screenings. The patient would work with the team to have care coordinated with other health care providers which would include appointment scheduling, information sharing, medication reviews, and follow-up. Case management would assist the client getting to appointments, connecting with other recovery support services, addressing needs and family engagement (if appropriate). If the primary chronic condition focus changes, the patient may transfer to a different team that addresses that particular condition if they choose to. As the client progresses in attaining recovery care goals, the focus of the team will be to continue care coordination, provide resource to the patient, and meet any arising needs. For members in managed care, the OTP HH team will also engage with the member's managed care organization for assistance in accessing other primary care, specialty care, and acute services. For patients that are self-referring, enrolled in Managed Care or are already engaged in OTP services, opportunity to participate in HH services will be offered and patients will progress through services as described above.

Name	Date Created	Type
OTP HH Flow Chart	9/17/2016 9:56 PM EDT	

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Records / Submission Packages

**RI - Submission Package - RI2016MH00040 - (RI-16-006)**[Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Health Homes Providers**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

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**Package Header**

<b>Package ID</b>	RI2016MH00040	<b>SPA ID</b>	RI-16-006
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<b>Superseded SPA ID</b>	N/A		

[View Implementation Guide](#)[View All Responses](#)**Types of Health Homes Providers**

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Designated Providers

**Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards**

- ☐ Physicians
- ☐ Clinical Practices or Clinical Group Practices
- ☐ Rural Health Clinics
- ☐ Community Health Centers
- ☐ Community Mental Health Centers
- ☐ Home Health Agencies
- ☐ Case Management Agencies
- ☒ Community/Behavioral Health Agencies

**Describe the Provider Qualifications and Standards**

All Health Home designated providers are Opioid Treatment Programs licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals as Behavioral Healthcare Organizations. Licensed status indicates that all programs are required to abide by the Rules and Regulations for Behavioral Healthcare Organizations. All OTP Health Home providers are accredited by independent accrediting bodies and certified by SAMHSA.

MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Effective MAT programs also provide services such as physical and mental health care, case management, life skills training,

employment support, integrated family support, and recovery support services. Health Home services build on existing MAT resources and infrastructure. Methadone treatment is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTPs), which have provided comprehensive addictions services but with limited integration into the broader health care or mental health treatment systems. The OTP Health Home is a Designated Provider as described in Section 1945(h)(5). The OTP Health Home builds upon the existing treatment system by developing into specialty treatment centers that provide the six (6) Health Home services in addition to the traditional comprehensive methadone addictions treatment.

If an OTP HH provider would like to be authorized to receive reimbursement for COE services, the OTP HH provider must submit an application to the State. The State will assess each COE application according to the Certification Standards for Centers of Excellence. The Certification Standards detail the requirements that the COEs are held to, including, but not limited to the staffing requirements, person-centered approach to care, care coordination activities, use of HiT, quality monitoring and reporting, as well as the scope of COE services which include complete biopsychosocial assessments and physical exams; observed medication inductions; individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis. The Certification Standards for Centers of Excellence are available on EOHHS' website at the following link: [http://testweb.bhddh.ri.gov/quick\\_links/excellence.php](http://testweb.bhddh.ri.gov/quick_links/excellence.php)

☐ Federally Qualified Health Centers (FQHC)

☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

## Provider Infrastructure

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### Describe the infrastructure of provider arrangements for Health Home Services

Opioid treatment programs are uniquely suited to provide health home services to opioid dependent patients receiving medication assisted treatment. Compliant with both federal and state statutes, OTPs are staffed by medical and clinical staff and have daily to biweekly contact with clients in a clinical setting. OTPs providing Health Home services are required to be licensed by the Department of BHDDH and demonstrate compliance with Rules and Regulations as determined through routine monitoring and audits. OTPs are also required to receive certification through SAMHSA and maintain independent accreditation.

To provide Health Home services, OTPs will be required to maintain a specific staffing pattern dedicated solely to the implementation of the six service domains identified by CMS. Staffing will be based on a ratio of a 125 patients per team. Teams will be organized by primary co-morbid condition if numbers allow (i.e. a Hepatitis C specific Health Home team, a COPD focused Health Home team), otherwise, patients will be organized on teams with many comorbid conditions or risk factors present. These teams will be led by staff trained and knowledgeable in the primary health concern of the patient. Presence in particular teams may be fluid based upon changes in the patient's presentation and primary concerns.

The COE staffing requirements, as described in the COE Certification Standards, include Drug Abuse Treatment Act (DATA)-waivered physicians, nurses (RN or LPN), Master's Level Clinician (clinician to patient ratio not to exceed 1:100), pharmacist, and a combination of licensed chemical dependency professionals, case managers and/or peer recovery coaches.

The following is a description of each core Health Home team member and their roles:

**SUPERVISING MD:** The OTP physician has primary responsibility for the overall treatment of the patient.

**Care Management:**

- Coordinate and review health assessment that identifies medical and wellness needs.
- Provide consultative support to provider Case managers to help identify the physical health needs of individuals and work with relevant organizations to develop a services plan and arrange for the delivery of physical health services as needed.
- Ensure individuals with complex, co-occurring physical health disorders are well understood or being served by primary care providers, as needed through regular phone contact, correspondence, to their medical and health promotion providers.
- Ensure that the individual's plan of care developed by the Health Home team integrates the continuum of medical, behavioral health services and identifies the primary care physician/nurse practitioner, specialist(s) and other providers directly involved in the individual's care.
- Ensure that the individual's plan of care developed by the Health Home team clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.
- Attend organizational staff meetings as needed to assess medical status and progress, coordinate medical and health promotion activities, and develop

solutions to problems other staff are experiencing.

- Collaborate with nurses in assessment of client's physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordination medical treatment.

#### Care Coordination and Health Promotion

- Ensure that individual plans of care clearly identify primary, specialty, behavioral health and community networks and supports that address identified needs.
- Ensure OTP clients have meaningful engagement with internal and community wellness and prevention resources for smoking cessation, diabetes, asthma, hypertension, etc., based on individual needs and preferences.

#### Individual and Family Supports

- Ensure the care plans reflects patient and family or caregiver preferences, education and support for self-management, self help recovery, and other resources as appropriate.
- Communicate/share information with individuals and their families and other caregivers as appropriate.
- With other team members, provide support and education to family members of clients to help them become knowledgeable about opioid dependence, collaborate in the treatment process, and assist in their family member's progress.

#### Referral to Community/Social Supports

- Participate in the development of agencies' policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and team, including follow-up and consultations that clearly define roles and responsibilities.

#### Continuous Quality Improvement

- Participate in agency continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management.
- Clinical supervision, education and training of the team pertaining to medical issues, as needed.

**RN SUPERVISOR:** This team member has primary responsibility for the implementation of health homes services and specific care plans. Nurses assist the physician in the monitoring of routine health screens, they conduct regular face-to-face assessments of clients, screen BMI and blood pressure, make referrals, monitor medications and assist in the coordination with outside providers, including hospitals. The RN supervisor is involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services.

The following is a detailed list of RN Health Home responsibilities:

- In collaboration with the team physician, coordinate, schedule and administer agency's assessment of clients' health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate substance abuse treatment with medical treatment. (comprehensive care management)
- Provide ongoing health assessments (identify health issues, behaviors, needs, barriers) and all other assessments, which are appropriate for the nursing scope of practice. (comprehensive care management)
- Build relationships with medical providers in the community, which will provide the team with a network of physical health resources. (comprehensive transitional care)
- Collaborate and regularly liaises with pharmacies, labs and community agencies based on consumer's health and wellness needs. (comprehensive transitional care)
- Refer clients to other health providers and other resources within the community when appropriate. (referral to community and social support services)
- Accompany consumers to medical appointments; facilitate medical follow up, when appropriate. (comprehensive care management)
- Provide supportive case management to families by ensuring they receive assistance with patient advocacy, information regarding program, team, or community health and educational resources, and referrals to appropriate community services and/or agencies. (care coordination)
- Support client access to services such as medical appointments, hospitals, transportation, housing services and social programs by methods such as providing health care information and contacting relevant programs/services. (care coordination)
- Act as an advocate for clients. (care coordination)
- Under the direction of the team physician, the nurse will develop, revise, and maintain medication protocols, policies and procedures. (care coordination)
- Provide support and education to family members of clients to help them become knowledgeable about substance use disorders, collaborate in the treatment process, and assist their family member in making progress. (family supports)
- Manage pharmaceuticals and medical supplies. (family supports)
- Facilitate wellness promotion activities such as smoking cessation, chronic condition self management, and nutrition. (wellness promotion)

**MASTER'S LEVEL TEAM LEADER/PROGRAM DIRECTOR:** A licensed clinician involved with identifying potential OTP patients, conducting outreach, assessing preliminary service needs, establishing a comprehensive care plan, developing an individualized Plan of Care with goals set in conjunction with the patient, assigning Health Home team roles and responsibilities, developing treatment guidelines and protocols, monitoring health status and treatment progress, and developing QI activities to improve care. These individuals are the bridge between clinical and Health Home services. Team leaders supervise case managers, facilitate team meetings and provide the necessary outreach and patient engagement strategies. Team leaders, in conjunction with the RNs, act as the healthcare liaison with community and institutional providers. Team leaders will participate in transitional care meetings and establish working

relationships with primary and specialty care practices, along with other specialty behavioral healthcare providers (CMHCs, residential treatment providers, etc.). They are involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services.

- Lead on development of health services plans at the treatment plan meetings; monitor each client's status and response to health coordination and prevention activities; and provide feedback regarding staff performance, and give direction to staff regarding individual cases and supervise members of health home team in the development of wellness and prevention initiatives; health education groups. Oversee primary functions of HH Team, including but not limited to:

- Provide on-going training to case managers in the recognition and management of chronic medical conditions. (health promotion)
- Coordinate and integrate disease self-management activities (improve integration within general health promotion practices practice). (care coordination)
- Provide effective discharge planning implementation/ continuity of care. (care coordination, comprehensive transitional care)
- Ensure quality communication with CMHCs, federally qualified health centers, hospitals, other providers, etc. (troubleshoot when necessary on issues). (care coordination)
- Develop and maintain working relationships with primary and specialty care providers, including inpatient facilities. (comprehensive care management)
- Consult with community agencies and families to maintain coordination of the treatment process.(referral to community and social support services, individual and family support services)
- Assure that team is meeting overall Health Homes goals. (comprehensive care management)
- Educate community health referral sources, perform clinical screens and participating, organizing and executing care-coordination and prevention. (health promotion)
- Design and develop prevention and wellness initiatives. (health promotion)
- Monitor Health Home performance and leads improvement efforts. (care coordination)

**CASE MANAGER/HOSPITAL LIAISON:** Encourage client towards self-management (i.e. if possible, encourage direct communication between the consumer-patient/caregiver and primary care provider; meet patients at their level in order to prepare them to self-manage their acute and chronic conditions). Enhance communication and collaboration between clients, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Advocate, make phone calls and facilitate connections when critical need emerges, and coordinate communication with key medical and social services involved with the patient's care upon discharge, when necessary.

1. Maintain good working relationship with medical and psychiatric units (know how to function in variety of medical inpatient cultures). (comprehensive transitional care)
2. Engage with the patient upon admission to the hospital. (comprehensive transitional care)
3. Communicate any noteworthy information back to the inpatient staff. (comprehensive transitional care)
4. Engage consumer and family in their discharge plan by providing them with resources and tools that enable them to participate in the formulation of the transition plan. (individual and family support services)
5. Collaborate with inpatient staff regarding discharge planning (determine the level of improvement and resources necessary for discharge). (comprehensive transitional care)
6. Upon hospital discharge (phone calls or home visit):
  - Assist client to identify key questions or concerns.
  - Ensure Client:
    - Understands Medications and knows how to take as prescribed
    - Has access to a nurse and physician to discuss any potential side-effects;
    - Is knowledgeable about indications if their condition is worsening and how to respond;
    - Knows how to prevent health problem from becoming worse;
    - Has knowledge of and transportation to all follow-up appointments.
  - Prepare client for what to expect if another level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
  - Review with Health Home team transition care goals, relevant transfer information (i.e., all scheduled follow-up appointments; any barriers preventing making appointments); function as resource to team members -- to clarify all outstanding questions. (comprehensive transitional care)
7. Establish a plan of return to hospital, if clinically appropriate, or if the community transition plan is not working. (comprehensive transitional care)
8. Coordinate transportation to drive client home and to ensure they are properly settled i.e. has appropriate food, etc. (comprehensive care management)
9. Provide advocacy in getting appointment, if necessary, or if to obtain answers needed to manage condition as necessary upon discharge. (comprehensive transitional care)

**CASE MANAGER:** The case manager is responsible for the implementation of the care plan. They provide direct support to the client in and out of the treatment setting. They are responsible for the following:

- In collaboration with the team physician and nurse, coordinate and schedule medical assessment of client physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate medical treatment. (care coordination)
- Provide practical help and support, advocacy, coordination, side-by-side individualized support problem solving, direct assistance, helping clients to obtain medical and dental health care. (individual and family support services)
- Provide nutritional, education and assistance with grocery shopping and food preparation as it relates to an identified medical issue (e.g., diabetes, etc.).



(individual and family support services)

- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness, as advised by the client's primary/specialty medical team. (comprehensive care management)
- Collaborate in the treatment process with primary and specialty care providers as required. (care coordination)
- Support the client to consistently adhere to their medication regimens (e.g., phone prompting, MI), especially for clients who are unable to engage. (comprehensive care management)
- Accompany clients to and assist them at pharmacies to obtain medications. . Accompany clients to medical appointments, facilitate medical follow up. (comprehensive care management)
- Provide education about prescribed medications (e.g. consistently discussing the purpose of medications, educating through written materials; enlist the help of other clients, etc.). (health promotion)
- Work with inpatient medical services to complete admission and discharge preparation when necessary; utilize personal health record to help patient self-manage; provide coaching/role playing for person's follow-up appointments. (comprehensive transitional care)
- Provide direct assistance to obtain the necessities of daily life, e.g., legal advocacy for consumers involved in the criminal justice system; benefits counseling (e.g., food stamps, home energy assistance, income tax, transportation, etc.). (comprehensive care management)

**PHARMACISTS:** Healthcare professionals who focus on safe and effective medication use. They are an integrated member of the health care team directly involved in patient care. Professional interpretation and communication of this specialized knowledge to patients, physicians, and other health care providers are functions which pharmacists provide, and are central to the provision of safe and effective drug therapy. Pharmacists are responsible for ordering, receiving, storing, and providing nursing staff with medication to be administered. They may review patient medication lists for safety and potential interactions.

There will be three collaborative positions shared across Health Home sites/agencies. These vital roles ensure consistency in implementation at each site and fidelity to the Health Home model.

The first of these positions is an Administrative Level Coordinator. This person will oversee the implementation of Health Home services at all agencies and act as the liaison to the State agencies supporting Health Homes. This Coordinator will participate in team meetings and work with staff to achieve fidelity to this proposed model. The coordinator will strategize with teams to encourage client participation, develop wellness programs, identify potential community partners and assist in outcome evaluation.

The second shared position is the Health Information Technology Coordinator. The responsibility of the HIT coordinator is to assist programs in the enhancement of their EHRs to effectively monitor program outcomes and to connect with the State HIE, or find other means to share meaningful data. Based on experience from the CMHO Health Home, RI recognizes the need to establish, with each EHR, a mechanism for tracking Health Home service events. This will be one of the first tasks of the HIT Coordinator. The HIT coordinator will work effectively with RI's Health Information Exchange – Current Care – to capitalize on the work that has already been done to include behavioral healthcare information compliant with all confidentiality requirements. The HIT coordinator will work effectively with the State Medicaid office and MCOs to establish linkages for the sharing of outcome data. In addition, the HIT coordinator and Administrative Level coordinator will continue work begun by BHDDH and SAMHSA to incorporate a pilot of the ASAM electronic assessment tool as a standardized assessment in the EHR.

Finally, the State intends to create a position of Health Home Training Coordinator. Provision of Health Homes services in an OTP represents a significant culture shift that will require specific ongoing training to identify and inform current resources and best-practices in Health Home delivery systems. Having a centralized training coordinator not only makes practical sense, but also promotes consistency. This person will ensure that programs have equal understanding of the goals and implementation of a successful Health Home program. The coordination of training will consider all disciplines involved in the effective delivery of Health Home services.

State oversight of the OTP Health Home program will be the responsibility of the State Opioid Treatment Authority housed at the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) and a representative of the State Medicaid Authority. These individuals will work closely with the shared coordinators, and leadership of each OTP site to ensure that programs are monitored for process fidelity and outcomes.

## Supports for Health Homes Providers

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Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

### Description

To facilitate the capacity to use health information technology, BHDDH will actively work with Health Home providers to become viewers and data sharing partners in the State's HIE - Current Care. BHDDH will capitalize on the progress made by our CMHO Health Homes in connecting to the HIE with provisions for compliance with 42 CFR Part II. A requirement to offer patients enrollment in the HIE along with an approved authorization to release is contained in State regulation for OTPs. All of our OTPs have EHRs. The State will coordinate information from the MCOs and Medicaid as has been done with the CMHO

Health Homes. MCOs will provide quarterly utilization reports to OTPs along with next day notification of hospitalization. The MCOs will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes.

BHDDH will coordinate efforts with OTPs and the Department of Health's Chronic Disease Self-Management program and other DOH related programs that will inform the strategies of the initiatives. These relationships were established during the planning process to ensure a holistic approach.

BHDDH will use our Client Information database (RIBHOLD) to provide outcome/trend data to providers and prevent dual enrollment with other Health Homes and duplication of services.

OTPs will be supported in transforming into Health Homes through participation in statewide learning activities, monitoring and technical assistance. BHDDH will modify its monitoring/evaluation instrument created for CMHO Health Homes for OTPs. This instrument was well received by providers and HH reviewers as it incorporates self-assessment with a departmental review of process and individual cases. Use of evidence based practice and provision of culturally appropriate, quality driven and cost effective services will continue to be a requirement of both licensing and contracts.

BHDDH will provide links to Health Home and Center of Excellence information on its website as a means of communication with providers and others.

## Other Health Homes Provider Standards

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### The state's requirements and expectations for Health Homes providers are as follows

OTP HHs must submit signed agreements to BHDDH attesting that the provider agrees to adhere to the requirements set forth in the OTP HH Certification Agreement. Such agreement describes the OTP HH's care coordination responsibilities, staffing requirements, reporting requirements, and activities related to collaboration with other healthcare providers.

If an OTP HH provider would like to be authorized to receive reimbursement for COE services, the OTP HH provider must submit an application to the State. The State will assess each COE application according to the Certification Standards for Centers of Excellence. The Certification Standards detail the requirements that the COEs are held to, including, but not limited to the staffing requirements, person-centered approach to care, care coordination activities, use of HIT, quality monitoring and reporting, as well as the scope of COE services which include complete biopsychosocial assessments and physical exams; observed medication inductions; individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis. The Certification Standards for Centers of Excellence are available at the following link:  
[http://testweb.bhddh.ri.gov/quick\\_links/excellence.php](http://testweb.bhddh.ri.gov/quick_links/excellence.php)

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Records / Submission Packages

**RI - Submission Package - RI2016MH0004O - (RI-16-006)**[Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Health Homes Service Delivery Systems**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

**Package Header**

Package ID RI2016MH0004O

SPA ID RI-16-006

Submission Type Official - Review 1

Initial Submission Date 9/29/2016

Approval Date 12/9/2016

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Superseded SPA ID N/A

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

☒ Fee for Service☒ PCCM**The PCCMs will be a Designated Provider or part of a Team of Health Care Professionals**☒ Yes  
☐ No☒ The State provides assurance that it will not duplicate payment between its Health Home payments and PCCM payments.☒ Risk Based Managed Care**The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals**☒ Yes  
☐ No**Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services**

For OTP HH, the language included in the contract between EOHHS and the MCOs addresses the goals of the program, patient eligibility, provider eligibility, descriptions of core functions and responsibilities of OTP HH providers, assessment and reporting requirements, OTP HH team composition and staffing levels, descriptions of services provided by OTP HHs, and MCO responsibilities. MCO responsibilities include contracting with OTP HH to serve their members, coordinating care with the member's use of other MCO covered services, referring other MCO members who meet the enrollment criteria to OTP Health Homes, providing OTP HH with reporting to facilitate the coordination of medical and behavioral health care, use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes, oversight to ensure contract requirements are being met, assist the OTP HHs with identifying necessary components of metric reporting, adhere to the reporting date requirements based on a reporting calendar, adhere to continuity of care requirements, including maintenance of relationships between members and treating providers (including beneficiaries transitioning into the managed care organization), holding the member harmless, and ensure that the OTP HH are submitting HIPAA compliant claims data for services delivered under the OTP HH.

For MCO enrollees active with OTP Health Homes, the MCO will leverage the care management provided at the Health Home and will not duplicate services. The MCO will work collaboratively with Health Homes to ensure all the member's needs are met.

For clients enrolled in OTP Health Homes, the OTP is the lead provider for all care coordination/care management services. To facilitate collaboration, both

the OTP and the MCO will be provided with necessary data from the Department.

On a quarterly basis, the Department will provide the MCO with a list of their enrolled members in OTP Health Homes. The format for this file will be agreed upon between the MCO and EOHHS. MCOs store this information in a central database that can be accessed by all relevant staff. On an interim basis, OTP Health Homes will inform the MCO directly of any new HH enrollees/disenrollees.

Weekly, the MCO will send the OTP Health Home a health utilization profile for the most recent twelve-month period, for every new member of the OTP Health Home Program. The format and transmission method for this health utilization profile will be mutually agreed upon by the OTP Health Home and the MCO. The elements of the health utilization profile will include, but will not be limited to, physician office visits (primary care and specialty), prescriptions, emergency room (ER) visits, and inpatient stays.

The OTP Health Home will provide the MCO with a high-level summary of the care plan, in a format agreed upon by the Health Home and the MCO.

The MCO will inform the OTP Health Home of all inpatient admissions prior to discharge, and will engage the OTP in a collaborative discharge planning process, whenever possible. Upon discharge, the OTP Health Home will contact the member to ensure all appropriate services and supports are in place to prevent future hospitalization. The OTP will coordinate with the MCO to obtain any necessary authorizations for in-plan services, as appropriate.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	Type
No items available		

**The State intends to include the Health Home payments in the Health Plan capitation rate**

- ☒ Yes  
☐ No

**Assurances** ☒ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☒ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☒ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

#### ☒ Other Service Delivery System

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MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

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**The State's Health Homes payment methodology will contain the following features**☐ Fee for Service☐ PCCM (description included in Service Delivery section)☒ Risk Based Managed Care (description included in Service Delivery section)☒ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)☒ Tiered Rates based on☐ Severity of each individual's chronic conditions☒ Capabilities of the team of health care professionals, designated provider, or health team☐ Other

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

There is no variation in payment for OTP HH. CEOs will be certified at two levels to ensure timely access to MAT services. Level 1 providers are those that have the ability to meet the requirement of admitting all individuals within twenty-four (24) hours of referral. Level 2 providers are those that have the ability to meet the requirement to admit all patients within forty-eight (48) hours Saturday through Thursday and within seventy-two (72) hours for referrals made on Friday. Level 1 providers will receive an enhanced rate for induction to support the requirement of having physician availability seven (7) days per week. Level 1 providers will receive a payment of \$600 and Level 2 providers will receive a payment of \$400 for induction.

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

The Health Home payment is a weekly, bundled rate per patient. The OTP provider initiates a claim for the weekly rate, using a new procedure code for Health Home services. The provider may make a weekly claim using the Health Home code for a patient who receives an average of one encounter per week in one month. Encounters will be recorded in fifteen minute increments and providers will be required to submit monthly encounter data to BHDDH. Effective July 1, 2016, OTP HH services and the related methadone treatment costs will be an In-Plan benefit for all product lines and the OTP HH weekly rate will be \$53.50. This rate does not include the cost of methadone treatment and is based on the utilization of OTP HH services across all lines of business.

Effective July 1, 2016, any OTP HH provider which is certified as a COE will be able to bill for two new procedure codes; a one-time procedure code for induction activities at the time of initial enrollment/assessment and thereafter, a procedure code for COE services to be billed weekly until date of discharge to community, but no longer than six months. The rates are as follows:

- Level 1 COE: \$600.00 One-Time Induction; \$125.00 Weekly COE services
- Level 2 COE: \$400.00 One-Time Induction; \$125.00 Weekly COE services

The Induction payment reimburses for the initial assessment process (complete biopsychosocial assessments, physical examination, observed medication induction, and initial individualized treatment planning). The weekly bundled rate accounts for all COE services (continued individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis). COE rates do not include the cost of the medications. Providers will need to bill for medications separately.

## Assurances

☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

**Describe below how non-duplication of payment will be achieved** There are no 1915(c) waivers in RI - everything is under 1115 demonstration waiver authority. EOHHS and BHDDH will identify clients who receive targeted care management through Ryan White funding and also receiving OTP Health Home services and coordinate on a case-by-case basis to eliminate duplication of services. EOHHS has included contract language in the OTP provider responsibilities section that OTP HHs are to coordinate with the Integrated Health Home (IHH) and Assertive Community Treatment (ACT) program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, IHH and OTP Health Home.

☒ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

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Records / Submission Packages

**RI - Submission Package - RI2016MH0004O - (RI-16-006)**[Follow](#)[Request System Help](#)[← All Reviewable Units](#)**Health Homes Monitoring, Quality Measurement and Evaluation**

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

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**Package Header**

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Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Rhode Island will annually assess cost savings using a pre/post-period comparison. The assessment will include total Medicaid expenditures for the intervention group. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditures. RI has current Medicaid data on all clients who received OTP HH services. RI also distributed a survey to OTP patients which included questions that assess their use of primary care physicians, specialty care, and Emergency rooms. This survey will be distributed again for a pre/post evaluation.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

BHDDH will actively work with Health Home providers, and specifically with the HIT coordinator, to increase use of the State's HIE - CurrentCare. BHDDH will capitalize on the progress made by our CMHO Health Homes in connecting to the HIE with provisions for compliance with 42 CFR Part II. Participation in the HIE means that programs will have ready access to health care information from other sources such as PCPs, hospitals, pharmacies and labs. While OTPs are required to access information through the State's Prescription Monitoring Program, not all prescription information is contained there (only certain schedules). Participation also means that OTPs can share information (with client consent) so that other providers are aware of a client's participation in an OTP along with other relevant treatment information.

Information from MCOs and Medicaid will be provided to OTPs in routine reporting. MCOs will provide quarterly utilization reports along with next day notification of hospitalization. This will help OTPs effectively transition their patients and provide seamless care.

BHDDH will coordinate efforts with OTPs and the Department of Health's Chronic Disease Self Management program. Clients can be referred to these programs through email and tracked for follow through by DOH, with a report back to the referring provider.

BHDDH will use the RIBHOLD system to provide outcome/trend data to providers and prevent dual enrollment with other Health Homes.

OTPs will be supported in transforming into Health Homes through participation in statewide learning activities, monitoring and technical assistance.

Physicians will have the opportunity to participate in DOH's Grand Rounds.

BHDDH will provide links to Health Home information on its website as a means of communication with providers and others.

OTPs will work with the HIT coordinator to develop systems for effective communication with patients such as texting, use of social media, twitter, and email alerts.

**Quality Measurement and Evaluation**

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- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

Go to HHQM Reports

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